Regal Care Trading Ltd

Brenalwood Care Home

Inspection report

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20 June 2022

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Brenalwood Care Home is a residential care home registered to provide personal care to up to 38 people across two floors. The service provides support to people aged 65 and over including people living with dementia. At the time of our inspection there were 24 people living at the service.

People's experience of using this service and what we found
The environment was unhygienic, poorly maintained, and in need of extensive renovation to make it safe and comfortable for people living in the service. Infection control measures were poor and placed people at risk. Risks to people's health and welfare had not been considered or addressed by the service, and staffing levels were not adequate to provide safe, person-centred care.

Staff did not have the training, knowledge, or support in all areas to ensure people were well cared for. The training staff had received and the systems in place to ensure staff were competent or had understood the training were not always effective.

People were not supported to eat and drink properly, their personal care needs were not always met, and their dignity and independence were not considered. There was insufficient information in peoples care plans to support them appropriately with the varying degrees of dementia within the service. Staff did not have the time to engage with people in a meaningful and positive way.

The registered manager did not have the appropriate skills or training to safely and effectively manage the service. There was a lack of understanding of how to make decisions for people with their best interests, or knowledge of the Mental Capacity Act 2005.

End of life care planning was poor, with no advanced planning for how people may wish to have a respectful and dignified death. People did not have access to information in ways that would be accessible for them, the provider had not considered people who may have different communication needs or how to support them.

Systems and processes to monitor the safety and quality of the service, and the safety and welfare of the people who lived there were ineffective and poorly monitored. The provider and the registered manager had not identified the shortfalls and issues that had been identified by us on inspection, and had failed to act on issues which had been identified by external professionals, such as the local authority, and the clinical commissioning group.

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 received their prescribed medicines safely, and new staff were recruited in line with best practice guidance.

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 27 March 2019).

Why we inspected
The inspection was prompted in part due to concerns received about the environment, staffing, infection control and the management of the service. A decision was made for us to inspect and examine those risks.

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

We have found evidence the provider needs to make improvements. Please see the safe, effective, caring, responsive, and well-led sections 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 the inadequate leadership and management of the service at this inspection. Governance systems were ineffective and failed to ensure the safety of the premises and equipment or identify people were not being treated with dignity and respect. There were insufficient staff to care for people, risks had not been identified or addressed and infection control was poorly managed all of which placed people at risk of harm.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Brenalwood Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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 three 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
Brenalwood Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Brenalwood Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 used observations to gather evidence of people's experience of care and we spoke with one person who used the service, and 11 relatives about their experience of the care provided. We spoke with seven members of staff including the nominated individual, registered manager and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records including three people's care and medicines records. We looked at five staff files in relation to recruitment and a variety of records relating to the management of the service.

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.

Preventing and controlling infection

- Infection prevention and control (IPC) measures in place were poor, which placed people at risk of acquiring infections and associated implications to their health.
- The premises were unclean and unhygienic. People's ensuite facilities, communal toilets and shower rooms were very dirty which increased the risk of spreading infection. We observed dried faeces in several areas around the service, including on the headboard of a person's bed.
- Despite having previous COVID-19 outbreaks cleaning had not been formally reviewed. There were no enhanced or more frequent cleaning schedules in place to minimise risks to people and staff.
- The systems for the provision of personal protection equipment (PPE) were poor. Not all masks and gloves were kept in enclosed wipeable dispensers, increasing the risk of cross infection.
- The kitchen was extremely dirty and poorly maintained. Staff showed poor understanding of cleaning and safe food hygiene management, including risks of cross contamination when preparing raw and cooked foods. We reported our concerns to the Environmental Health Department who visited the service, confirming our findings as well as identifying other areas of concern.

Failure to have robust systems in place to manage infection prevention and control placed people at the risk of harm. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Immediately after the inspection the provider arranged for an external company to complete a deep clean of the kitchen on Friday 24 June 2022 to mitigate immediate risks to people and staff.

Assessing risk, safety monitoring and management

- Risks to people's health, welfare and safety had not been adequately assessed and managed which placed them at risk of avoidable harm.
- The registered manager and staff were not following the providers falls policy to ensure risks to people were identified and managed. This included ensuring people were wearing appropriate footwear to reduce the risks of slips, trips and falls. We observed people were wearing no shoes, only socks on slippery wooden flooring or ill-fitting slippers."
- "Where people required bed rails to keep them from rolling out of bed, risk assessments had not considered the bed occupant, the bed, mattresses and bed rails were compatible and fitted correctly to reduce the risk of entrapment of the person's neck, head and chest. There were checks of mattresses and bed rails in place, however, these were not robust enough to pick up and address the shortfalls identified during our inspection."
- "Free standing wardrobes in people's rooms were not always secured to the wall presenting a risk of being

pulled over by the person which could result in a fatal injury."
● Personal Emergency Evacuation Plans (PEEP's) intended to identify the equipment and level of assistance needed to safely evacuate people had not considered all factors that may affect a safe evacuation, such as sensory impairment, night sedation or heightened anxieties with associated behaviors. These factors may mean in the event of a fire a person required a higher level of support than was documented, particularly at night.
● "Floor plans of the premises displayed in the reception area showed the layout of the building on each floor, identifying zones and where fire extinguishers were positioned. The plan had lots of crossing's out and rewriting on it making information unclear in the event of an emergency. Records demonstrated staff were provided with fire safety instruction during induction, however, this reduced the risks relating to staff but not for others who may be visiting the service, including people's relatives and other professionals who may be unfamiliar with the service, and layout."

Systems were either not in place or robust enough to manage safety effectively. This placed people at risk of harm. This was a breach of Regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff told us there was not enough staff to provide people with appropriate personal care, such as showers, accessing the toilet on a regular basis, and people had to wait for staff to provide care.
● Observations of mealtimes confirmed there were not enough staff to ensure people were adequately supported to eat. People were left to eat independently, had little interaction with staff and therefore did not receive the encouragement or practical help they needed to eat, either independently or with support.
● "The registered manager told us they had kept staffing numbers of one senior and four care staff across the daytime, and three-night staff, even though the number of people had reduced. However, staff told us due to the deterioration in people's dementia and or health their needs had increased.
● "There was a dependency tool in place to assist the registered manager to assess people's dependency needs and the numbers of staff required. However, the registered manager was unable to demonstrate how the staffing levels were kept under review to ensure that, for example, staff absence was appropriately managed to reduce impact on people and to accommodate people's choices, such as getting up early in the morning."
● The service was heavily reliant on temporary agency staff to cover sickness and vacancies. Staff told us agency staff did not always turn up and high levels of sickness were not being managed. Comments included, "Same staff who call in sick or just didn't turn up," and "When staff don't turn up, people have to wait longer, it's not fair they have to wait, but we only have one pair of hands, double ups take two staff of the floor."

Failure to have sufficient numbers of skilled, trained and competent staff placed people at risk of harm and failed to ensure their personal care needs were met in a timely manner. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited in a safe manner, including obtaining Disclosure and Barring Service (DBS) checks which provide information, including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Staff were aware of their responsibility to raise safeguarding concerns to the registered manager.
● "The registered manager had failed to recognise when to report safeguarding concerns to the local

authority safeguarding team and had failed to notify CQC. This included unwitnessed injury and bruising, and regular altercations between people. Stakeholders had pointed this out to the provider the end of May 2022, and reporting was now being done."

● There was no formal system or process in place to monitor, address and learn from safeguarding concerns, complaints or incidents. Incidents of unidentified bruising or distress were not investigated to ensure action was taken to remedy the situation, protect people, prevent reoccurrence and make sure lessons were learned and improvements made as a result.

● The high incidents of unwitnessed falls where people had sustained injuries were not being fully analysed in line with the providers policy. They had failed to identify trends and themes and where action could be taken to minimise incidents of falls.

Using medicines safely

● People were receiving their prescribed medicines in a supportive way. However, further work was needed to ensure people's care plans and protocols contained sufficient information to support staff to administer 'when required' medicines (PRN), particularly medicines to relieve anxiety.

● Systems were in place to help ensure medicines were managed safely, to detect errors and take prompt action if any errors were found.

● Staff had received medicines training and had their competency assessed to ensure they administer these safely and completed medicine records correctly.

Visiting in care homes

● Peoples relatives told us visiting was easy, and they could arrive whenever. Visitors were required to have their temperature taken and sign in the visitors' book. Visiting was facilitated in people's bedrooms.

Inadequate

Is the service effective?

Our findings

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

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

Adapting service, design, decoration to meet people's needs
- The environment was not safe, well maintained or adapted to meet peoples' diverse needs.
- Extensive renovation and replacement works are required throughout to ensure the premises are suitable, well maintained and fit for purpose.
- "Internal décor was old, dirty, or missing. Window frames were rotten and uncleanable, toilets and hand wash basins in peoples' ensuites and in communal toilets, showers and bathrooms were in poor repair and leaking. The ground floor shower room had an offensive sewer smell coming from water outlets."
- The sealant round the backs of handwash basins and around taps was contaminated and limescale was present causing a reservoir for microbes which can cause cross contamination.
- "The extractor fan in one ensuite was broken, this was addressed during our inspection after we highlighted the issue. Curtains were hanging off poles and rooms were in urgent need of redecorating."
- Bedrooms on the ground floor had direct access to outside spaces. These doors were not used, and in most instances did not fit the frames properly.
- The decking area outside the communal lounge was rotten. A sheet of hardboard had been affixed to cover it. However, there was no consideration for the trip hazard this created.
- Equipment and facilities were not clean and fit for use. Sensor mats in peoples' rooms to alert staff if they fell were engrained with dirt, increasing the risk of germs being transferred to the person should they fall, or touch the mat increasing the risk of acquiring and spreading infection.

The premises and equipment were not clean, secure, or properly maintained. This placed people at risk of harm. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The registered manager did not have a clear understanding of the requirements of the Mental Capacity Act 2005.
● Mental capacity assessments were poorly completed; information was repetitive.
● The registered manager's knowledge around best interest decision making was poor. They had failed to consider people's capacity, ability to consent and ensure decisions, such as do not attempt cardiopulmonary resuscitation (DNACPR) authorisations were made by those who had legal authority to do so.
● Where people were subjected to DoLS to restrict leaving the building for their safety, these had been assessed and authorised by the local authority.

Failure to take into account people's capacity, ability to consent and ensure decisions were made by those who have legal authority to do so is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff received training via an eLearning platform. There was no system in place to assess the quality of training staff received to ensure they had understood the content, test their skills, knowledge and competence to support people properly and safely. One member of staff told us, "I've, not had any training here in relation to diabetes and dysphagia (difficulty swallowing), we should have training, as we do have a few diabetic people."
● Staff received regular supervisions. However, they were not effective in supporting staff because they failed to address staff's professional development and did not review learning gaps.
● "The registered manager was not adhering to the providers training policy to ensure staff received appropriate training for their roles and responsibilities. There was no evidence of additional training for staff appointed in specialist roles as identified in the policy, apart from the end of life champions. One end of life champion who had achieved a certificate in end of life care in 2012 and another had recently registered to complete a qualification in end of life care."
●The registered manager and maintenance person had not received adequate training to fulfil their day-to-day responsibilities with regards to monitoring and maintaining the health and safety of the premises, people and staff. This meant the environment was not always safe and risks had not been identified or managed.
● Records showed staff had completed a range of mandatory and specific training relevant to needs of people, such as the use of bed rails, dementia and challenging behaviour. However, these skills were not put into practice when interacting with people. Staff did not know how to effectively support people with dementia. They lacked the skills to understand the wider aspects of people's dementia related needs including communication, unsettled behaviours and dysphagia (difficulty swallowing).

Staff did not have the appropriate knowledge, skills, or training to provide safe and effective care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● "Staff received induction when starting at the service, which included shadowing experienced members of care staff. We were provided with evidence for one new staff member who had undertaken Care Certificate training during their induction. 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. However, there was

no specific mention of the Care Certificate in the providers training policy."

Supporting people to eat and drink enough to maintain a balanced diet
● Mealtimes were chaotic and not well organised due to not having enough staff.
● Observation of mealtimes saw people left to eat independently with little interaction from staff. Therefore, they did not receive the encouragement or practical help they needed to eat more, either independently or with support.
● We observed a person struggle to eat their meal with no assistance as staff had not cut the food up into manageable amounts, this did not promote dignity or independence.
● People were not involved in decisions about what they would like to eat and drink. Food options from a four-week menu were written on a small whiteboard at the back of the dining room which was not accessible for many people. One member of staff told us, "People don't have much input into the menu."
● No picture menus were provided to aid choice, instead people were presented with two options for lunch. We saw one person declined both options, but they were not offered any other choice. They were provided with one of the options, which they did not eat and had no midday meal.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The majority of people living at Brenalwood were living with dementia ranging from early onset to advanced stages. Their care plans were not person-centred or reflective of best practice or evidence-based guidance for dementia care to ensure effective outcomes were achieved.
● The registered manager was not proactive in assessing and reviewing people's needs when they changed and failed to actively involve people in making decisions about the care and treatment they received.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● "The local district nursing team regularly visited the service to assist with people's treatment and medicines. However, complaints had been raised by the district nursing team about staff and the care provided. These complaints had not been fully addressed."
● The service contacted the GP when they had identified concerns relating to people's health.
● People did not have plans in place to support proper oral hygiene. One person had no teeth and no dentures. This was not identified in their care plan or their nutritional plan. Another person had a very poorly maintained toothbrush in their room, we raised this with staff who disposed of the toothbrush and replaced it. There was no assessment or care plan in place for this person to maintain their own oral hygiene.

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 we rated this key question 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; Supporting people to express their views and be involved in making decisions about their care

- People were not treated with respect and compassion or given emotional support when needed. Although staff were observed to treat service users kindly, care was delivered intuitively and not driven by best practice.
- Care was delivered in a task-based way rather than considering people's needs and wants.
- Staff were dismissive of people's requests for assistance. We observed one person requested to go to the toilet, staff responded by sending them to the toilet on their own with the assurance they would come and help. Staff then failed to assist the person.
- Staff were not always respectful towards people and failed to make them feel like they mattered. The registered manager and staff referred to people as "wanderers", "feeders" and "double up's".
- The cook told us they re-heated and liquidised the remnants of the previous day's meal for "The feeders" today. This practice meant the food may lose some of its nutritional value and was also disrespectful and undignified.
- The lack of maintenance of the environment, including people's bedrooms and ensuite facilities compromised their dignity and did not show respect. Curtains in people's rooms were hanging off the poles or had no curtains at all which failed to maintain people's privacy.
- People were not actively involved in making decisions about the care they received. No evidence was available to show people had input into their care plans or were consulted on decisions surrounding their care.

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

- The service did not understand the importance of ensuring staff have the right skills and time to know when and how to give people the right support they need.
- Care was not delivered in a way that met people's needs or reflected their choice and preferences. There was a culture to get people up early in the morning despite knowing if this was their choice. At our visit on 16 June 2022, at 07:00 13 people were observed up and dressed in the communal area. The registered manager said, 'These people had been got up by the night staff, but they would not have got anyone up before 6am. "It was not possible for three staff to properly wash, or shower, shave, and dress 13 people in one hour.
- Feedback from people's relatives included personal hygiene could be better. Comments included, "(Person) smells a bit, they would like showers more regularly. Baths and showers not 100%, not sure how frequent, sometimes they might smell a bit, hygiene something you can pick up the smells," and "(Person) does not get regular showers, they have to ask, sometimes they are not always clean."

● "Insufficient and available staff meant people were not supported to maintain their independence with dignity; including eating and drinking and support to manage their continence needs. One member of staff told us, "Certain people who need their pad changed and need hoisting are okay until after lunch, we just don't really have the time." This meant people may be sitting for long periods of time in wet or soiled garments and at risk of their skin breaking down and pressure wounds developing."

People were not treated with dignity and respect; their privacy was not maintained and they were not involved in making decisions about their care. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Care plans did not provide staff with the information they needed to ensure people received person-centred care and treatment appropriate to their needs and personal preferences. They failed to address the types of and varying stages of peoples' dementia and how this affected their day to day living in terms of their independence and wellbeing.
- Important relevant and specific information to help staff deliver personalised and responsive support to people and promote wellbeing was lacking. There was no detailed and relevant information to tell staff why an individual may become agitated or anxious, any triggers that might heighten their anxiety or ideas about how to distract or engage positively with them.
- Care plans lacked information about people's interests, social activity and stimulation.
- People were not supported to engage in activities which were socially or culturally relevant to them. The service employed one member of staff to coordinate activities for the 24 people living in the service. Although, they tried to engage with multiple people at the same time in activities there was not enough time or staff to provide meaningful interactions.
- "People were all seated within one large room, which acted as the communal lounge, dining area and activities area. This made the room jumbled, busy and proved to be disorientating for people. Regular altercations of raised voices and swearing between people occurred were not managed appropriately which had a negative effect on others."

Care was not delivered in a way that met people's needs or reflected their choices and preferences. This was a breach of Regulation 9 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 service did not always make information available to people in accessible ways. There was a Service User Guide which provided accessible information, however, this was not up to date, such as the management and staff working in the service. There was no further evidence provided which showed information, such as care plans and the menu were made available and accessible to people who may have

different sensory or cognitive abilities."

Improving care quality in response to complaints or concerns

● The system for receiving and responding to complaints was ineffective.

● One complaint had been received by the service in 2022. No analysis was completed with regards to the complainants ongoing concerns regarding the cleanliness and maintenance of the service, and their relative's hygiene and nothing had been done to address the issues raised.

End of life care and support

● Peoples end of life wishes were not considered or assessed by the registered manager. The only documented wishes were for what was to happen after death, such as burial or cremation.

● There was no information regarding people's choice of where their final days would be, how they would like their needs managed, such as pain management, or how they would like their spiritual or cultural needs met.

● The registered manager did not follow any best practice guidance, or pathways for meaningful end of life care.

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; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong, Continuous learning and improving care

- Systems to assess and monitor the quality and safety of the service were ineffective. These have failed to identify the issues found during the inspection and by other professionals, including the local authority safeguarding team, clinical commissioning group and the environmental health agency.
- The registered manager was supported by the providers operations director and estates manager. None of the senior management team were able to demonstrate how they assured themselves the service was safe, fit for purpose and people were receiving appropriate care.
- Although audits of the service had been carried out, they were ineffective as they had not identified, captured and managed risks to ensure people received care and treatment in a safe way. This meant the compromised quality and safety issues found on inspection had not been identified or responded to appropriately and without delay.
- The provider and registered manager did not understand the principles of auditing and how results of audits informed the quality monitoring and assurance cycle.
- Audits provided were no more than records of data; there was no robust analysis of the information to see what it is telling you and identify the strengths and weaknesses of the service. Trends, themes or root causes were not looked for.
- Systems for checking the safety of equipment were ineffective and therefore risks to people's safety had not been identified and acted upon. Beds, mattresses and bed rail checks had not identified ill-fitting bed rails and mattresses were non-compliant with health and safety standards. This exposed people to a significant risk of injury, and death by entrapment and suffocation.
- The registered manager did not show an understanding of duty of candour. They were unaware of when things had gone wrong and as a result could not be open and transparent.

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

- Staff lacked leadership and guidance which resulted in people not receiving the care and support they needed to stay well and engaged.
- The notice board in the reception contained a copy of the providers core values setting the standard staff should work towards. The values referred to as the 6C's: care, compassion, courage, communication, commitment and competence. However, the care delivery we observed was not in line with these principles.

● Neither the registered manager or staff knew what the visions and values of the service were or demonstrate how they would apply the values to their work. One member of staff said, "I've seen something, but I can't remember."
● The registered manager did not promote an open and inclusive service. Staff told us they did not feel supported by the registered manager and found them unapproachable at times. One member of staff said, "On a good day you can approach them and talk, but on a bad day there is lots of shouting."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff were informed through staff meetings of failures found by local authority but improvement plans and what role staff should take in making improvements were not shared.
● "Staff told us they were not given the opportunity to be involved in proposing new ways of working or suggesting improvement."
● Systems to check if people's life and experiences of living in the home could be improved upon in any way were ineffective.
● The registered manager was unable to demonstrate how people's views and experiences were explored and demonstrate how involvement in their care was promoted.
● Surveys to obtain people's feedback about the service had been completed on their behalf by a staff member. The registered manager had no arrangements in place to show how people's or their representatives' feedback was considered or used to drive improvement.
● People who had no-one acting on their behalf had not been provided with information to access advocacy services to enable them to voice any concerns or preferences.

Working in partnership with others
● Although the provider, operations manager and the registered manager have worked well with other professionals to make immediate improvements where needed the quality monitoring systems in place had failed to identify and mitigate the risks.

Systems and processes in place to assess, monitor, and improve the quality and safety of the service were not robust or effective. The failure to provide oversight of the service placed people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not delivered in a way that met people's needs or reflected their choices and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Peoples dignity and respect, and independence was not promoted or encouraged by the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager had failed to take into account people's capacity, ability to consent and ensure decisions were made by those who have legal authority to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment were not clean, secure, or properly maintained. This placed people at risk of harm.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Failure to have sufficient numbers of skilled, trained and competent staff placed people at risk of harm and failed to ensure their personal care needs were met in a timely manner. Staff did not have the appropriate knowledge, skills, or training to provide safe and effective care.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to manage safety of people effectively, and a failure to have robust systems in place to manage infection prevention and control by the provider.

The enforcement action we took:

We have issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to have robust systems and processes in place to assess, monitor, and improve the quality and safety of the service.

The enforcement action we took:

We have issued a warning notice.