Golden Age Care Ltd

Breach House

Inspection report

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16 June 2022
22 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
Breach House is a residential care home providing personal and nursing care for up to 34 older people. At the time of our inspection visit there were 18 people living at the home.

Breach House accommodates people in one building over two floors. Thirty two people at the home had en-suite facilities in their bedrooms. Other people shared bathroom and shower facilities.

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

People's risks were not managed. Some people had damage to their skin and wounds from poorly managed pressure area care. Staff were unclear about what to look for in relation to monitoring people's skin health. One person needed thickened fluids due to a risk of choking. This was not in their care plan or risk assessment. Staff did not always provide the person with drinks that were thickened.

People's care plans and risk assessments did not contain the information staff needed to provide safe and effective care. Important information regarding people's known risks was missing. For example, details regarding a change to a person's swallowing capability following an admission to hospital were not in the person's records, and staff were unaware of the steps needed to keep the person safe.

People did not always have access to health services in a timely way. One person had raised with staff that they did not have good vision through their glasses. The person told us that they had told staff, however we could not find evidence that action had been taken.

Peoples' medicines were not managed safely. Medicines were not always administered in line with their prescriptions. People's medicines were missed due to time constraints without the medical advice or authorisation to do so safely. effectively to ensure staff were recruited safely and the risk of the spread of infection was not well managed.

People were not always treated with dignity and respect. Some people told us they were not always spoken with in a manner that was respectful. During the inspection we witnessed staff were not always respectful in how they spoke with people. Staff did not always take actions to ensure people's dignity was protected. People's care plans were brief and task orientated. They did not contain person centred information and were not always updated or reviewed when people's needs changed. There was limited support for people to avoid social isolation, follow interests or take part in any activities.

There were no systems or processes in place to ensure the service was well led. The service had failed to identify and act on risk. The provider did not provide a service that met people's individual needs and preferences. There were no systems in place to audit medicines, incidents, accidents, care plans or complaints to identify risks, themes or lessons learnt.

People and their families were not involved in their care planning and there were no systems in place to seek feedback from people using the service. People did not always feel they could raise concerns with the staff supporting them.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 11 May 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected

The inspection was prompted in part due to concerns received about staffing, management of risks and lack of management oversight. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well Led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Breach House on our website at www.cqc.org.uk.

Enforcement and Recommendations

We have identified breaches in relation to safe care and treatment, person-centred care, staffing and good governance at this inspection.

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

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

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Care Quality Commission

Breach 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 three inspectors and one 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
Breach 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. Breach House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post. However at the time of inspection they were in the process of resigning from this post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 15 June 2022 and ended on 22 June 2022.

We visited the location's service on 15 June 2022, 16 June 2022 and 22 June 2022.

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 reviewed a range of records including eight people's care records, accident records, handover records and medicine administration charts. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed three agency staff profiles. We spoke with eleven people who lived at Breach House. We spoke with eight members of staff including the compliance manager, team leader, care staff, domestic staff, cook and two agency staff. The registered manager was unavailable for the inspection. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with two people's family members. We spoke with a district nurse and the GP. We spent time speaking with and observing the care of most of the people living at the service over the course of our site visits and observed lunch.

Inadequate

Is the service safe?

Our findings

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

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

At our last inspection the registered manager and provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

Assessing risk, safety monitoring and management

- Risks were not always identified, assessed and well managed. For example, there were no care plans to inform staff how to manage risks to people with pressure sores or people at risk of choking.
- Risks to people's safety were not always well managed because risk assessments and care plans did not accurately reflect people's current needs. Records did not demonstrate that regular pressure relief was given to people with pressure sores and there were no records to ensure people at risk of choking were given thickened fluids. This exposed people to the avoidable risk of becoming unwell.
- One person had skin damage to their foot. Their risk assessment and care plan contained no information about the skin damage or support needed to reduce the risk of deterioration. There were significant gaps in records to show when the person had been repositioned and frequent recordings of gaps in excess of four hours and, on occasion, gaps of over six hours.
- Another person had skin damage to their hip. Management did not know the detail of the damage or when it occurred. Their skin care risk assessment was out of date and their care plan stated they had no damage to their skin.
- One person was recently admitted to the home from hospital. Their health had changed which meant they needed thickened fluids to reduce the risk of choking. Their hospital discharge letter had not been opened for over one week, so staff did not provide this person with safe care. Despite making management and the provider aware of this risk on the first day of inspection, we continued to observe staff give this person drinks which were not thickened during the second day of inspection and we had to intervene to stop the person from potentially choking on an un-thickened drink that had been given to them by a member of care staff.
- People at risk of falls were not monitored or re-assessed after a fall to minimise the risk of it happening again. One person had three falls in April. Their falls risk assessment and care plan had not been reviewed after these falls to minimise the risk of them happening again.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised our concerns over how risks were being managed directly with the local authority immediately following the inspection. Also, where necessary we contacted safeguarding regarding the specific incidents.

Using medicines safely

● People did not receive their medicines in line with their prescribed instructions. One person's Medication Administration Form (MAR) stated on 27 May 2022, 'Morning meds omitted. Sleepy unable to safely administer.' However, the daily records for this date at 09:15 am stated the person 'Chatted with other staff or residents, chatted a reasonable amount, chatted to a member of staff was content.' The MAR also stated on 1 June 2022, "Morning meds omitted. Asleep unable to safely administer'. The daily records for this date at 10.29am state the person 'Chatted with other staff and residents.' This meant this person did not receive their morning dose of seven prescribed medicines on either of these days. This included medicines to treat high blood pressure, low mood and reduce the risk of heart attacks. There is no record in the person's daily records that the medicines had not been administered or that additional observations had taken place or medical advice was sought.

● One person's MAR stated on 18 May, 29 May, 31 May and 9 June 2022 that their midday medicines had been omitted due to morning medicines being given late. This meant they did not receive their two prescribed medicines on all of these days. When we spoke with a senior staff member, they told us, "I am not the only one that does this, but yes we do omit people's medicines if we are running late." They also told us that they did not escalate this to the management team or seek medical advice before omitting someone's medicines. The senior member of staff, when talking about the person's midday medicines said, "Well they are only pain killers." They could not confirm to us that they carried out any checks on the person following this medicine omissions on these dates to understand if they were experiencing pain.

● One person had been discharged from hospital and the MAR stated they had a change to the dosage of one of their medicines. However, a senior member of staff had administered the previous dose as well as the revised dose, and meant the person received three times the stated dose of the medicine. The compliance manager was seeking medical advice during our inspection.

The provider had not ensured the proper and safe use of medicines. This left people at significant risk of serious health conditions being left untreated. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised our concerns over how medicines were being managed directly with the local authority immediately following the inspection. Also, where necessary we contacted safeguarding regarding the specific incidents.

Systems and processes to safeguard people from the risk of abuse

● Systems did not ensure people were safeguarded from the risk of abuse or improper treatment and that staff understood their safeguarding responsibilities.

● Injuries such as bruising and skin tears were not routinely reported or recorded by staff or investigated to understand the cause and minimise the risk of it happening again.

● One person had unexplained bruising to their palm and wrist. There was no record of the bruising. Staff and management could not explain when or how it occurred or that it had been investigated. There had been no referral to the adult safeguarding team. The compliance manager made a safeguarding referral after our inspection.

● The culture at the home meant some staff practice did not meet expected standards and abusive practice was observed. When we spoke with people about how staff spoke to them, they told us staff could be, "Touchy" "Bossy and forceful" and one person said, "Staff are good at telling you what to do." A serious safeguarding incident was witnessed by two inspectors, where a person was spoken to in a verbally abusive manner. Although immediate action was taken to suspend the two members of staff, this was only after this had been raised by the inspection team.

● Staff did not always take action when people told them they needed help. One person told us they had

woken in pain in the early hours of the previous night and had reported this to the staff member on shift. The staff member had told the person they would get pain relief; however, the person had not received this. We reported this with staff at 8.45 am, however it was not until 1.45pm that it was finally administered after the person said they were still experiencing pain.

Systems and processes to prevent abuse and improper treatment did not operate effectively. This placed people at risk of harm and was a breach of Regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised our concerns with the local authority immediately following the inspection. The compliance manager raised a safeguarding alert immediately after the incident of verbal abuse.

Staffing and recruitment
● Feedback from staff and our observations strongly indicated that staffing levels did not support the timely and safe delivery of care.
● One member of staff said, "On paper [staffing] is ok but in reality it's not enough. We used to have an activities coordinator five days a week, a laundry assistant. It's all gone now. Nothing has improved since the last inspection, it's worse. We don't have staff meetings and supervisions are out of date."
● People had to wait long periods of time to be given their meals which caused some people distress. We had to alert staff to this and check when their meals would be served. We observed lunch on 15 June and it started at 11.45 am and did not finish until after 3 pm. Staff told us there was not enough staff to provide the support people needed.
● The provider became increasingly reliant on agency staff who did not always have the knowledge or understanding to spot emerging risks to people's health. For example, we spoke with two agency workers about how they managed people's skin health, and if they were aware of any people who had or were at risk of pressure sores. One agency staff member could not tell us what was required of them in checking people's skin. Both agency staff referred to people's pressure sores as 'bruises' and were unable to tell us where these pressure areas were.
● The provider had not considered the skill mix of staff to ensure they were able to respond and meet people's changing needs in a safe manner.

There were not sufficient numbers of suitable staff to effectively meet people's needs. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a recruitment system that ensured only suitable staff were employed. Staff applications contained reference checks on previous employment and also checks with the Disclosure and Barring Service (DBS). 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.
● Where agency staff were used we checked their agency profiles, this contains information on the checks and backgrounds of the staff. We found it contained enough information to give the provider assurances to the suitability of the agency staff they were using.

Learning lessons when things go wrong
● The provider had not acted to ensure lessons were learnt from the previous inspection, to ensure risks to people were understood, monitored and managed.
● The inspection identified repeated areas of concern related to people's care and treatment. There was no oversight of risks and people were exposed to avoidable harm.

● Accidents and incidents were not consistently reported or recorded by staff. There was no oversight, monitoring or analysis of accidents and incidents to reduce the risk of them happening again.

Preventing and controlling infection

● We were not assured the provider was preventing visitors from catching and spreading infections. Some visitors told us they were not always prompted to wash their hands, on entry to the home. People did not always have effective support with their hygiene. People's hand and fingernails appeared unclean. People told us that they did not receive regular baths or showers even though some people had asked staff. Staff told us that people did not have baths or showers and this was confirmed by the records we looked at.
● We were assured the provider was meeting shielding and social distancing rules.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely. We saw staff use PPE appropriately.
● We were assured the provider's infection prevention and control policy was up to date.
● We were assured the provider was accessing testing for people using the service and staff.

Visiting in care homes

●At the time of our inspection there was no restrictions on visiting and relatives were able to visit their loved ones at a time convenient for them.

Inadequate

Is the service effective?

Our findings

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Some people living at the service were being deprived of their liberty, however, the service was not always working within the principles of the MCA.
- One person told us that they were prevented from leaving the communal area during the afternoon. They told us that staff would redirect them to a seat. We asked staff and they confirmed that this was how they managed this person. Staff told us that they felt the person had capacity to make decisions for themselves. When we looked at the persons care records a capacity assessment had not been completed and a DoLS application had not been made. It had not recorded they were carrying out this restrictive practice in the persons best interest. As a consequence, there was no legal basis for this restriction.
- When we looked at other people's care records, they did not have capacity assessments, and it was unclear what information was available to inform staff about people's individual capacity to make decisions. Whilst staff were able to tell us about the principles of the MCA and had received training, they could not tell us how they ensured that people were involved in decisions about their care and support.

Care was not always provided with the consent of the relevant person or in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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

- People's needs were not routinely assessed. There were significant gaps in assessments and care records.
- Assessments and care plans were not updated following changes in people's health. For example, when people had falls or when they had developed skin damage.
- There was no system to ensure that information about changes in people's needs was shared with staff, such as when they had been re-admitted to the home from hospital.

● Care was not delivered in accordance with people's needs. This was because staff lacked guidance on how to support people safely, based on current information about their needs.
● Records did not provide an accurate view of the care and treatment provided to people. We observed several occasions when records did not accurately reflect the care provided. For example, one person was visibly unhappy and told staff and the inspection team how they felt. Staff did not record what this person had told them, and daily notes described them as being happy, with no concerns.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always encouraged to eat and drink enough and records did not ensure that people's hydration and nutrition could be effectively monitored. Staff we spoke with were unaware of people's specific hydration and nutritional needs.
● One person was at risk of losing weight and had lost four kilograms in two months. There was no care plan to ensure regular monitoring of this person's intake or to ensure staff encouraged this person to eat enough. They were given a very small portion of food; staff left the person unobserved with the food and they ate all of it. When staff returned to collect the plates, they did not ask if the person had enough to eat or offer a second serving to encourage any potential of weight gain.
● Another person was given a very small portion of food. They ate only a couple of mouthfuls. Staff did not identify why the person only had a small amount and this person was not offered alternative foods to eat. The meal chart for this person stated they were given a standard portion of food and ate all of it. This did not reflect what we saw and meant that it was not clear what support or intervention the person needed to achieve a healthy nutritional intake.
Adapting service, design, decoration to meet people's needs
● Areas of the home needed attention and decoration. There was no system to ensure that essential maintenance was carried out to ensure that the home environment was safely accessible to everyone. For example, we checked the wheelchairs that were currently in use. Out of twelve wheelchairs, three wheelchairs had brakes that did not work, one wheelchair had no arm rests, one wheelchair had no safety strap and one wheelchair had no suitable footplates, meaning that six of the twelve wheelchairs were not safe for use and could have posed a significant risk to people using them.

Immediately after highlighting the wheelchair concerns to the provider they told us they had ordered eight new wheelchairs and taken the unsafe ones out of use.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
●There was not enough information or assessments in people's care records to reflect people's needs and choices. Staff were not clear about what care and support people needed, for example staff were unclear on what support was needed to manage a person's pressure areas or to manage the risk of falls.
● Staff did not always support people to access healthcare services in a timely way. For example, One person told us that they were experiencing discomfort when looking through their glasses, and that when they had told staff they were told they were "on a list", however continued to say that "Nothing has been done about it." They told us it had been, "a problem for a long time". We reported this to a staff member who said they were aware, and this person's family said the glasses were fine. We later established the 'list' referred to was when the optometrist was next due to visit which the staff member said, "Could be a few months." We also found in the persons care records that they had no family.
● Where people's needs had changed or their health deteriorated this was not recorded or discussed in staff handovers, meaning that staff did not have the necessary information to ensure that people could access healthcare services in a timely way.

Staff support: induction, training, skills and experience

● Permanent staff had completed training in the areas the service identified as mandatory, such as safeguarding and moving and handling as part of their induction training. However, there was not a system to ensure that training was regularly refreshed. There was no oversight of the skills or competence of the agency workers and our conversations with two of the agency workers did not provide us with assurances that they understood what was required to meet the individual needs of people living at Breach House.

● Staff told us they did not have regular supervision. One member of staff said, "I do not remember the last time I had any supervision." There were no records of supervisions taking place and there was no system to ensure that staff remained up to date with their skills and knowledge of their roles or of people's needs.

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

● On the first day of inspection, we saw a member of staff assist one person to the toilet. The staff member held the door open with their foot and talking to another member of staff even though the person was in the toilet, and the member of staff had seen the inspector walk past. This was in an area where people were walking past and did not provide the person with dignity or respect. We raised our concerns immediately with a senior member of staff and when we arrived back at this area the staff had continued their conversations and had continued to prop the door open with their foot.

● Staff were not always respectful of how people felt. One person had been expressing they were in pain since the early hours and were not given pain relief until the afternoon, even though their prescription would have allowed for them to have pain relief earlier.

● We also observed how staff supported people. We saw that staff did not take the time to have meaningful discussion or engagement with people. People were taken to the toilet at key times before meals and there was no discussion with people outside of these times to ask or observe if they needed assistance with their personal care needs.

● People had raised concerns with us over staff being assertive or disrespectful in the way that they carried out their caring tasks. However, there was no mechanism to support people to express their views or experiences of care and this meant the provider and management were unaware of how people felt.

● People were not supported to have baths or showers. The hygiene chart in people's care records showed that some people were not getting any showers or baths. When we discussed this with staff, they could not tell us why this was happening. People we spoke with told us that they would like a bath or shower but were not given the opportunity. One person said, "I used to have a bath at home, I don't have one here, nobody has told me why." When we looked at the hygiene charts for this person, we could not find any recording of when they had a bath or shower in the past month preceding our inspection visit.

●There were no formal systems in place to involve people to express their views or to be involved in their care.

People were not always treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 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; End of life care and support, 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

- We reviewed eight people's care records. There were not sufficient care plans and risk assessments to provide the guidance for staff to meet people's individual needs or preferences.
- Care plans were limited in information and task orientated. They did not contain any personalised information about people's likes, dislikes, life history or how they would like to spend their time. There was no system to ensure care plans were reviewed or updated when people's needs changed.
- There was not enough detail in care plans to indicate people's wishes at the end of their lives, even though the service cared for people at the end of their lives.
- Staff did not know what interests people had and we did not see any attempts made to provide personalised support to people over the days of the inspection. One person told us how they used to enjoy sewing and knitting but had not had any opportunity to do it at Breach House. They told us, "It is boring, you wouldn't want to live here. Nobody ever asks what you would like to do."
- There was no support for people to avoid social isolation, follow interests or take part in activities.

Care and treatment did not meet people's needs and reflect their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 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.

- People did not always have the support they needed to communicate. For example, one person preferred to use gestures and hand signals to communicate, however we did not see staff take the time to communicate in the persons preferred way.
- No effort had been made to ensure that the environment was conducive to effective communication. There were two televisions showing different channels with the volume turned up in the communal area where most people were seated. Even though on both the first and second days of our inspection we had raised concern with staff regarding the noisy environment, when we returned on the third day of our

inspection this continued. This meant that there was increased background noise and it was difficult to speak with people.

● There was some pictorial information for people on an information board in a corridor, however this was not in an area where people spent their time and there was not sufficient accessible information for people to inform them of what was happening in the home.

We recommend that the provider put systems in place to ensure the Accessible Information Standard is met.

Improving care quality in response to complaints or concerns

● There was no system to record, investigate or action any complaints from people or their relatives.

● There was no system to gather feedback form people or relatives about the care and support provided that was provided.

The provider did not have a system to identify, record or respond to complaints. This was a breach of regulation (16) (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. 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.

At our last inspection the provider's systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;
● Governance systems and processes were not in place or operating effectively to monitor risks to people's care or identify when those risks had changed.
● There were no audits or quality assurance systems. For example, risk assessments and care plans were significantly out of date and did not accurately reflect people's current needs.
● The provider did not have sufficient oversight of the care provided to people. Risks were not always assessed, and staff had not always followed instructions to keep people safe. Records were not always completed accurately or clearly to demonstrate safe practice and enable effective monitoring to take place.
● At the time of the inspection, the registered manager was absent. The compliance manager had recently returned from leave and did not have enough support from the provider to manage the service in the registered manager's absence.
Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was a high use of agency staff and the provider had not implemented extra checks or support to ensure agency staff had the appropriate knowledge or understanding of people's needs.
●The provider did not have robust systems in place to ensure all staff were following their safeguarding policy and procedures to protect people from harm.
● People were exposed to potential harm as staff lacked clear direction and support and not all staff understood their roles and responsibilities. Staff were not given honest feedback about how they were performing, and where improvement is needed.
● The provider had failed to maintain securely an accurate, complete and contemporaneous record in respect of each person living in the home, staff recruitment and training, and governance checks.

Continuous learning and improving care
● The provider could not demonstrate how they had learnt from the findings of the previous inspection or

implemented changes to improve people's care.

The provider's systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● People and their families were not involved in their care planning. Important information relating to people's individual characteristics was not captured in people's care plans or assessments.

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; Working in partnership with others
● The provider did not understand their responsibility to be open and honest when things had gone wrong. What we found during inspection did not match the assurances the provider had given to CQC and the local authority over action they had taken following concerns received by CQC prior to the inspection.
● The provider did not have a system in place to support an approach that was open and transparent. People were unable to feedback their experiences of care and this meant that the provider was not open to how people felt about their care and support.

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 Care and treatment did not meet people's needs and reflect their preferences.

The enforcement action we took:
We imposed a condition to restrict people being admitted to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

The enforcement action we took:
We imposed a condition to restrict people being admitted to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care was not always provided with the consent of the relevant person or in accordance with the Mental Capacity Act 2005.

The enforcement action we took:
We imposed a condition to restrict people being admitted to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm.

The enforcement action we took:
We imposed a condition to restrict people being admitted to the service.

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 Systems and processes to prevent abuse and improper treatment did not operate effectively. This placed people at risk of harm.

The enforcement action we took:

We imposed a condition to restrict people being admitted to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was no system to record, investigate or respond to complaints.

The enforcement action we took:

We imposed a condition to restrict people being admitted to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems were either not in place or robust enough to demonstrate safety was effectively managed.

The enforcement action we took:

We imposed a condition to restrict people being admitted to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitable staff to effectively meet people's needs.

The enforcement action we took:

We imposed a condition to restrict people being admitted to the service.