Reach Care Services Limited

Reach Care Services - Arden House

Inspection report

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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
Reach Care Services – Arden House is a residential care home providing personal care up to a maximum of 24 people. The service provides support to older people, people living with dementia and people who have a physical disability. At the time of our inspection there were 17 people using the service.

People's experience of using this service and what we found
The service was not well-led, and a closed culture was present. Safe and effective governance systems were not in place which meant people were at risk of harm. The provider did not have robust oversight, and when concerns were raised, they did not appropriately respond to promote safety and improve care.

Staffing levels were not safely assessed and reviewed. There were not enough appropriately trained staff to meet peoples' needs. Lessons were not learnt when things went wrong, and people were not protected from harm. Safety risks were not appropriately identified, reviewed and acted upon by staff, and oversight was not effective. Medicines were not managed safely, and risks relating to infection prevention and control were present.

People were at risk of dehydration and malnourishment and were not actively involved in their care planning and reviews. People's representatives and health professionals were not able to freely visit and faced restrictions from staff. Staff undertook tasks which were outside of their scope of competence which placed people at risk of harm. The provider had failed to appropriately supervise their staff, and staff had not received effective training to keep people safe.

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.

Staff did not treat people with dignity and respect. Kind and considerate care was not promoted in practice. People were not treated as individuals and their rights were not upheld.

People, or their representatives if appropriate, were not supported to be involved in the care planning process. Responsive care planning did not take place for people who experienced changing needs or health deterioration. Meaningful social opportunities, engagement and activities were limited, and people were at risk of social isolation.

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 2 May 2019).

At this inspection we found the service had deteriorated and the rating has changed to inadequate.

Why we inspected
The inspection was prompted in part due to concerns received about safe care and treatment; safeguarding; staffing; person-centred care; privacy and dignity and good governance. A decision was made for us to inspect and examine those risks.

We found evidence during this inspection that people were at risk of harm from these and other concerns. Please see the safe, effective, caring, responsive and well-led sections of this full report.

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

Enforcement
We have identified breaches in relation to safeguarding people from abuse; safe care and treatment; staffing; premises and equipment; nutrition and hydration; person-centred care; dignity and respect and good governance at this inspection.

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.

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 time frame 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.

Reach Care Services - Arden 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 2 inspectors.

Service and service type
Reach Care Services – Arden 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. Reach Care Services – Arden 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 start of our inspection there were 2 registered managers', 1 of which was also the nominated

individual and provider. 1 registered manager applied to cancel their registration with the Commission during the inspection, they will be referred to as the 'registered manager' within this inspection report. The other registered manager, who was also the nominated individual and provider, will be referred to as the 'provider'.

The provider also appointed an interim manager during the inspection time frame.

Notice of inspection
This inspection was unannounced. Inspection activity began on 13 January 2023 and ended on 3 March 2023. We visited the service on 17 January 2023 and 10 February 2023. Inspection feedback was given to the provider on 3 March 2023.

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. This also included 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.

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
During our visits we used observations to help us understand the experience of people who could not talk to us. We spoke with 7 people who used the service and 13 of their representatives. We also received feedback from healthcare professional teams who had contact with the service and provided support to people.

We spoke with 12 members of staff. These included care staff, team leaders, catering staff and domestic staff. Furthermore, we spoke with the registered manager, interim manager, the finance and operations manager and the provider. The nominated individual is the provider, and therefore responsible for supervising the management of the service.

We reviewed a range of records during the inspection, this included recruitment documentation for 2 staff. We also reviewed care records for 6 people and viewed medicine and supplementary records for multiple people during the inspection. We asked the registered manager to send us other records which we reviewed away from the care home. These records included care plans, risk assessments, monitoring documentation, staff rotas and staff training records. Additionally, we requested some policies and other records relating to the management and oversight 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.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Systems and processes were not robust to help protect people from abuse. Records indicated staff had completed safeguarding training. However, the staff we spoke to had limited knowledge of what types of abuse they may encounter. Furthermore, staff were not able to tell us how to report concerns outside of the care home.
- The provider failed to act upon concerns of potential abuse. For example, health and social care professionals shared concerns with the provider about restricted access at the care home and their inability to undertake appropriate assessments. These concerns were not responded to appropriately to ensure people were protected and had access to clinical care and support.
- The provider, and their staff, failed to report allegations of abuse without delay. For example, during the inspection timeframe a significant allegation of abuse was made. The provider and registered manager did not ensure this was reported to the local authority safeguarding team, to seek appropriate advice and guidance to help safeguard other people.
- Lessons were not learnt when things went wrong. The provider did not act promptly when concerns were raised, which had placed people at further risk of receiving inadequate care. During the inspection timeframe we completed 3 safeguarding alerts to the local authority due to our concerns for people. We identified 1 person had been at risk of receiving inadequate care and support following a change in health. And 2 people had been at risk of receiving care which inspectors considered neglectful.

Systems and oversight were not robust to protect people from abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider temporarily closed the care home due to the severity of concerns. This meant the care home became 'dormant'. People and their representatives were supported by the local authority to find alternative care and housing.

Assessing risk, safety monitoring and management

- People were at risk of pressure sores and further skin deterioration. Pressure sores can occur due to immobility, and other contributing health factors. We found people were not encouraged to mobilise regularly, despite their care plans stating they needed staff to support them to do so. People's care plans and risk assessments contained conflicting information. This meant staff did not have access to clear information about how to support people which put them at risk. For example, 2 people's care plans did not consistently record they needed support from 2 staff to help them reposition correctly. This meant people were at risk of receiving support from 1 staff which may have compromised their safety.

● People were at risk of weight loss and dehydration due to ineffective risk assessment and the provision of inadequate care. We found risk assessments were not correctly completed or were not completed regularly. For example, 1 person had experienced significant weight loss, and regular weight monitoring using an appropriate tool had not taken place. Furthermore, we found records could not be relied upon due to inconsistent recording. For example, fluid intake was not being correctly monitored or reviewed for people at risk of dehydration.
● People were at risk of further health decline and poor outcomes when receiving treatment for an infection. During the inspection timeframe, records showed 3 people received oral antibiotics for an infection. We found care plans were not updated to reflect people's health condition and how they should be monitored whilst they were receiving antibiotics. This meant assessments did not take place to consider additional risks relating to hydration and nutrition, mobility and skin health.
● People were at risk of injury. Risk assessments had not been completed for people where bedrails were used, and 2 people were using this type of equipment.
● Appropriate guidance was not in place to ensure staff provided safe and effective support to those who had diabetes, which placed them at risk. For example, 1 person had a protocol which was no longer reflective of the support they required; and safety monitoring had not taken place.

Assessments had not been completed or were not robust to mitigate risks to people. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were at risk due to poor maintenance of the environment. We found extensive mould was present on the walls in the external laundry room due to a water leak near to an electric box. Risks associated with mould particles which may have transferred to people's clothing had not been recognised, and appropriate cleaning had not taken place.
● People were at risk of harm in the event of a fire. Fire doors were not safe and operating appropriately. We found the screws had come loose on 1 bedroom door fire closure, this meant the door did not fully close, and would not have provided protection in the event of a fire. Another bedroom door closure was heavy set, this meant the door closed fast and forcibly which posed a risk of injury to people using this door.
● People were at risk of injury from scalding. 1 bathroom had a boiler cupboard within it, and hot copper pipes were exposed. Despite a lock being available on the door, it was found to be unlocked and accessible.
● Extensive water damage was visible on the ceiling of the visitor's lounge. We reviewed maintenance records which evidenced the roof had leaked since March 2022, which had also impacted upon the safe operation of electrics. The records were not clear regarding the action taken, nor planned, and a prompt review with responsive action had not taken place.

The provider had not ensured the premises and equipment were sufficiently maintained, cleaned and secure. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Safe staffing levels were not robustly assessed or reviewed which placed people at risk of harm. There was not enough staff to meet people's needs. The registered manager told us they determined safe staffing levels using dependency assessments; however, these did not consider the specific support needs of people and their associated time requirements.
● The registered manager told us they reviewed daily records and completed daily observations to assist them with reviewing dependency levels. However, daily records and our own observations did not evidence people received safe care. For example, daily records indicated people were not assisted with their

continence needs regularly, and one person told us they had to wait for staff support, which at times they found distressing.
● Staff were detailed to work extensive shift patterns. The registered manager told us this was an error on the documents; however, we saw several recorded examples of staff working overnight and then a 12-hour day. This meant there may have been times where people were not safely supported by staff.

The provider had not ensured there were sufficient numbers of staff available to meet people's needs. Robust systems were not in place to calculate and review staffing requirements at the care home. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider undertook specific checks when recruiting staff. This included Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

Using medicines safely
● Medicine processes were not safe. People were not supported correctly with their medicines and written guidance was not always available to staff.
● People's medicines were not always stored correctly, and in line with regulatory requirements. We found medicines were not always returned to the pharmacy when no-longer prescribed for people.
● Some people were prescribed medicines which needed to be taken at least 30 minutes before food. We found the required time frame between administration of this medicine and food, was not always followed. Furthermore, the directions were not correctly recorded. This meant the medicine was not administered as prescribed.
● People were prescribed high risk medicines which were not known by staff. Furthermore, appropriate risk assessments were not in place. For example, 1 person was prescribed blood thinning medicines, which meant they were at high risk of bleeding should a fall, skin abrasion, or impact to their body occur. We found risk assessments and guidance for staff were not in place. This meant appropriate emergency review and assessment may not have been sought in the event of an incident.
● People prescribed medicines on a 'when required' basis did not have robust written plans in place, or there was not a plan in place at all. For example, a 'when required' medicine may be pain relief to administer in the event of aches, pain or a headache. We found 1 person's records did not detail what staff should be looking for, to decide if 1 or 2 tablets should be administered. 1 staff member told us people did not have written plans, and when we asked them how they would know what to administer and when, they said, "We know what medicine to give and when".

The provider failed to ensure the safe management, oversight and administration of medicines. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The provider failed to ensure people were protected from the risk of infection.
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection. We found people's toiletries and personal wash cloths were left in communal bathrooms, and fabric handtowels were in communal toilets.
● We were not assured that the provider was using Personal Protective Equipment (PPE) effectively and safely. Staff did not always recognise the need for effective hand washing and safe use of PPE. We observed one staff member complete medicines administration for people whilst wearing the same pair of disposable

gloves, and no washing of hands took place. This had placed people at risk of cross infection.

● We were not assured that the provider was responding effectively to risks and signs of infection. Staff were completing complex wound dressings without the knowledge of district nurses. This had placed people at risk of infections due to unsafe and unauthorised practice.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found extensive mould on the walls of the external laundry room and shared our concerns with the local authority environmental health team due to our concerns for staff.

● Visiting did not take place in line with current government guidance. Visitors, which included people's representatives and health professionals, experienced unnecessary restrictions when visiting people. This meant people's representatives and health professionals had to telephone and arrange their visit in advance of attending. This approach to visiting did not prioritise the social and health needs of people and did not consider their human rights.

Infection risks to people were not assessed, prevented, detected and controlled safely. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Staff support: induction, training, skills and experience

- Staff had not completed the training required to effectively undertake their roles and keep people safe. We could not rely on the training records provided to us. We raised concerns with the provider, and they undertook a review of staff training and records. The provider told us, following their review, they were not confident in the knowledge and skill base of the staff they employed.
- We found staff lacked knowledge and understanding to meet people's needs. For example, the registered manager told us staff had completed specific training and competency checks surrounding blood glucose monitoring, and the administration of certain medicines. However, staff told us they had not completed this training. We asked staff what they would do if people appeared unwell overnight with pain, or health decline due to diabetes. 1 staff member told us they would offer a person something to eat. Another staff member told us they would wait for a team leader to arrive in the morning. This varied approach did not evidence effective staff training and guidance was in place.
- Staff were undertaking duties which they were not trained to complete and were outside of their scope of competence. For example, staff were completing complex wound dressings without appropriate training and authorisation. This meant people were at risk, and staff were not appropriately supervised by the provider.
- Staff told us they had completed training relating to the Mental Capacity Act and associated principles. However, they were unable to explain their understanding and how they would apply the principles in practice. This meant there was a risk people may not always be supported in line with requirements. Staff competency assessments could not be relied upon, and systems were not in place to consider if training had been effective.

The provider failed to ensure staff received appropriate training and supervision for their role. This was a breach of regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

- People were at risk of malnutrition and dehydration due to inadequate care. People's needs were not appropriately assessed and reviewed. Oversight was not effective, and risks to people were not acknowledged nor acted upon.
- 1 person required nutritional supplements due to weight loss, and their risk of malnutrition. Staff did not effectively assist the person with these supplements. We found they were left at the person's bedside, and records were completed to indicate the supplement had been consumed.

● People's dietary needs were not recognised and considered. We found people with diabetes were not always supported with a low sugar diet, and options were not evidenced as provided. Furthermore, 1 person's records stated they had an allergy, but had been provided with food and drinks containing the products their recorded allergy related to. We spoke with the registered manager about this and prompted a review to take place with the person's doctor.
● People were not always provided with person-centred support to make meal choices and were not aware of daily menus. People's communication needs had not been considered, and menus were not available in pictorial formats. People told us they did not know what was for lunch, and when evening meal choices were provided, one person had difficulty understanding the verbal options provided by staff.
● Staff did not recognise the importance of meal timings and the support people required. 1 person had their breakfast later in the morning, and their lunch was provided approximately 30 minutes after they finished. This person was evidently not hungry, however, staff continued to encourage the person to eat and did not acknowledge the reasons for their disinterest.
● People had their meals left in front of them for extended periods of time, and staff offered no effective communication or support. Furthermore, when people said they did not want or like the meal, an alternative was not always offered.

The provider failed to ensure the nutritional and hydration needs of people were met. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● People were not supported in line with guidance and the law. We observed staff practice, and reviewed care records, which did not always appropriately assess and meet people's care and treatment needs. People were not supported to access consistent, effective and timely care or healthcare support when it was required. For example, one person experienced a decline in health, and staff failed to recognise this required appropriate medical review.
● Peoples' care plans and daily records were limited and contained conflicting information. Staff told us they had time to read care plans, however we found they were not knowledgeable about the specific needs of people, nor the appropriate guidance to follow. For example, staff were not confident in the action to take if someone with diabetes appeared unwell.
● People's needs had not been appropriately assessed which meant their care and treatment needs were not being met. We were told by visiting professionals their visits to people were restricted by staff. This meant people were susceptible to worsening health and poor outcomes. We found effective and timely referrals did not take place for people where specific health assessments were required. This included sharing appropriate information with district nurses relating to falls, skin and health changes.
● People's representatives were not always informed when their relative had a fall, their health condition changed, or they developed a pressure sore. The provider and their staff did not ensure effective support was provided to people which met their individual needs.

The provider failed to ensure people received the appropriate care and treatment which met their needs. Responsive timely action was not taken to refer people to specialist healthcare services. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

● Decoration required updating in many areas of the care home. The provider did not have an effective overall maintenance plan to review where redecoration and refurbishment was needed. We found some walls were stained with food, and the premises looked worn and tired in places.
● People and their representatives, where appropriate, were not consulted with regarding the decoration in their bedrooms and communal areas. We observed paintwork, which was chipped and marked, and broken accessories such as a towel rail, toilet roll holder and toilet seat.
● People were restricted on where they could receive visitors. Feedback from health professionals and representatives indicated unless people were cared for in bed, visiting would take place in the communal visiting lounge. This meant people were not able to routinely welcome visitors into an area of their choice.

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.
● Staff were not knowledgeable or confident in the principles of the MCA and were not knowledgeable of the people who had a DoLS authorisation in place. Staff told us they would look at the care plans to check which people had authorisations, however, we found care plans were poorly written and were not person-centred.
● Through observations and discussions, we found people were restricted from freely seeing visitors. Where people lacked mental capacity, decisions made on their behalf did not always include the views of their legal representative, nor the completion of appropriate best interest assessments.

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.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- Staff did not always provide personalised support and reassurance. On our first visit, some people appeared distressed in the afternoon, and staff did not check on their safety, nor did they offer any reassurance or support. We sat with those who appeared distressed, and they then appeared to relax and engage with us.
- Staff did not always treat people with kindness, nor in a caring way. At lunch time we observed staff pushing people's meals towards them and walking away. 1 staff member said, "Come on [person], just eat". 1 person told staff they did not want the meal, and staff said, "Come on, try it". Another person did not want any more of their lunch meal, and we spoke to a staff member about their dessert, the staff member said, "We don't do pudding until everyone else has finished mains. They all have a sweet tooth and won't eat their dinner if they see the pudding. It will be out in a minute, tell [person]".
- We found privacy and dignity were not priorities promoted in practice. At approximately 11.30am, 1 person told us they had not received any support with personal care. We reviewed this with staff, and we were told they had been assisted by a specific staff member. We asked to see records to demonstrate this support, and a staff member said they had made a mistake, and the person had been assisted by night staff. We again asked to view the records which supported this and found there were none. The person then received assistance after lunch.
- People were not supported in a respectful manner. 1 person told us they had not been assisted to maintain their dental hygiene for approximately 4 days and had not felt able to request this support from staff. We observed people were assisted to wear clothing protectors before their breakfast, and they were not assisted to remove these until the mid-afternoon. This did not uphold people's dignity. Furthermore, people were left with food particles around them for extended periods of time.
- Some staff showed little consideration for people's thoughts and feelings. For example, we observed staff ask people questions, and then move on to communicate with someone else before allowing the person time to answer.
- The provider did not support people's autonomy and independence. Staff restricted people from having free access to their representatives and health professionals. This meant people were unable to have visitors at a time of their own choosing. These actions were unwarranted, they were undignified, and did not uphold people's rights. 1 person's representative told us staff had moved their relative's bedroom and they had not been involved, nor informed. A significant period of time had passed before they became aware.
- When visiting professionals were able to review people, they were sometimes supervised by 2 staff. The

registered manager told us this was in response to 2 visiting professionals attending when there had previously been 1. This meant 4 staff, including health professionals, could be present when personal care and support had been provided to 1 person. The registered manager, and staff, failed to acknowledge and appreciate this was undignified and did not allow people to have privacy.

● People, or their representatives, were not always given opportunities to decide who supported them with their personal care. Care plans did not always explore people's choice, or whether they may prefer male or female staff to assist them. Furthermore, we found the language used in care plans was not respectful nor dignified. For example, 1 person's care plan stated, "[Person] is clumsy and does not focus". Another person's care plan said, "[Person] is fully compliant with personal care and changing of clothes".

● Staff spoke to people using terms of endearment, such as referring to them as "love", or "lovely". Care plans did not record people wished to be spoken to in this way, and this did not show respect nor dignity for people.

● 2 people's representatives told us when they visited their relative, their relative was not always wearing their own clothing. Furthermore, we were told when representatives were able to access their relative's bedroom, they found items which did not belong to them.

● When we undertook our first inspection visit on 17 January 2023, we found at least 2 people had unopened Christmas presents in their bedrooms from their families. Staff provided us with no clear explanation or evidence as to why people had not been supported to open their Christmas presents.

The provider failed to ensure people were 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) Regulations 2014.

● We asked people if they liked living at Reach Care Services – Arden House. 1 person told us, "I hope I don't have to stay", another said, "It's not so bad here, it could be worse".

● Despite our findings, and observations, some representatives were positive about the support provided by staff. However, representatives did not have free access within the care home, their visits were booked, and they told us they had limited insight. 1 representative told us, "I see what I am able to see. I don't know what happens past the visiting room". Another representative said, "I have never been asked to go anywhere but [visitors room], so I would not be able to tell you about the rest of the service".

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

- People, and their representatives, if appropriate, were not always involved in the care planning process. This meant staff did not empower people, and their representatives, to have choice and control of the care provided.
- Care plans were not person-centred and offered little insight into people's preferences and needs. Where people had legally appointed their representative to make decisions on their behalf, we found no evidence of this being facilitated. This meant people's opinions were not regularly sought.
- Care plans did not guide staff on specific frequencies when support should be provided. This meant people were left for long periods of time between specific care support and checks being completed. From our own observations, and review of daily records, we saw significant time had passed between personal care, assistance with mobility, and staff helping people to access the toilet. For example, one person's care plan said they needed assistance with personal care. We reviewed the person's daily support records and found personal care had not been detailed as provided for approximately 9 days.
- 1 person had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNAR) order in place. We were told by the registered manager this person was able to fully participate in their care planning. We found this DNAR had not been discussed with the person, and at no time had staff considered this needed to be reviewed with the person's doctor. We asked staff to ensure an appropriate review took place. This was arranged with the person and their doctor.
- People were not provided with end-of-life care and support which was holistically planned, and person-centred. The provider failed to ensure staff consistently captured people's detailed needs and end of life wishes.
- People's representatives were not always kept up to date of the care and treatment provided to their relative in the final days of life. One representative told us of two specific events that had not been shared with them prior to their relative's death. Another representative also felt they did not receive responsive communication when raising concerns for their relative prior to their death.
- Where specific considerations had been made at the end of life, such as specialist medicines being prescribed for people, we found records were not developed and maintained. This meant guidance was not available for staff to ensure the involvement of health professionals took place where it was required for specific end of life support.

The provider failed to ensure people received care which met their needs and preferences. This 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; 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.
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 have access to easy read versions of complaints procedures, nor safeguarding information. There were no pictorial activities posters, nor menus, and people appeared to have difficulty understanding staff and their communication methods.

● The registered manager told us, of the 17 people who were living at Reach Care Services – Arden House, 12 people were living with dementia. This meant orientation aids and appropriate communication tools were important. People were at risk of being disorientated because the environment was not designed to meet the needs of people living with dementia. For example, people had a black and white photograph of themselves on their bedroom door. These were not clear, and the provider had not considered how people living with dementia may recognise themselves in earlier photos, as opposed to those in current time.

● People were not supported appropriately with orientation. There was a board visible to people, to help their orientation, and the information displayed included the date, day of the week, and weather conditions. However, on our first visit this displayed the incorrect date, day of the week and weather conditions. Furthermore, the clock in the lounge had stopped working, and on 17 January 2023, a Christmas week activities poster was still on display.

● People did not have access to planned activities which met their social needs, and little consideration of people's interests and hobbies took place. The registered manager told us care staff provided activities twice per day. 1 person told us, "I do nothing here. I could not do without my daily paper". Another person said, "I only see [staff] when they come to do something or bring me something".

● People were at risk of social isolation. Those people who did not sit in the main lounge area experienced prolonged time without engagement. People who were cared for in bed had no planned social or emotional support provided to them which was not part of their personal care. We observed activities were limited, and not planned. On the first day of our visit, staff chose the activity 'bird bingo'. Not all people understood what the activity was, nor how to participate. We observed staff completed the activity for some people, which meant people had little meaningful involvement and engagement.

● People's care plans did not evidence staff sought in-depth information from them, or their representatives, to clearly understand their past and present interests, and what was important to them.

The provider failed to ensure people's care and treatment met their needs. We found people's social, emotional and orientation needs, and preferences had not been assessed and considered. This was a further breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● The provider had a complaints procedure; however, we were not assured it was robust, and records correctly captured all concerns received at the care home.

● People's representatives gave us mixed feedback relating to concerns and complaints. Some said the registered manager had been responsive to their contact, however, other representatives expressed concerns of how their communication was received and responded to. The complaints log at the location did not reflect all concerns which were raised with the provider. This meant we had little confidence in the records provided to us, and the governance at the care home.

Inadequate

Is the service well-led?

Our findings

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

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

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

- We found a closed culture operated at the service which meant people did not receive the care and support they needed. For example, representatives and healthcare professionals did not have acceptable access to the care home. Furthermore, some staff were defensive when we spoke to them about our concerns.
- The provider's governance systems were not effective; this had placed people at risk of harm. For example, the provider's monthly visits did not thoroughly and independently assess the standards of care provided to people and the governance at the care home. Instead, they recorded what had been undertaken by the registered manager.
- We found failures and breaches of regulation in many areas, which included medicines management; nutrition and hydration provisions; appropriate risk identification and actions; care planning; safeguarding processes; staffing; end of life care and support; and responses to concerns. The provider did not provide additional quality checks, and oversight, and had not identified or addressed the multiple issues we have covered in this report. This meant procedures were not robust, and people had been placed at risk of receiving care which did not met their needs.
- Health and social care professionals had raised concerns with the provider prior to our inspection. This included concerns relating to their access to people to review their clinical needs and to complete assessments. Despite this communication, the provider failed to act upon the concerns raised, and failed to appropriately review the service provided to people. This meant people did not benefit from a culture of continuous learning to improve care.
- During this inspection we found multiple breaches of regulation. These widespread failings did not demonstrate the provider had safe and effective oversight of the service provided to people, nor did it demonstrate to us an understanding of regulatory requirements for the safe care of people.

The provider failed to operate systems and processes to operate effectively. This included failures to assess, monitor and mitigate the risks to people's health, safety and welfare. The provider had also failed to effectively review and improve the quality of the service when concerns were shared by health and social care professionals. The provider's governance systems were inadequate and offered no assurance of oversight. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We wrote to the provider during our inspection due to our extensive concerns of people receiving poor-quality care. The provider told us they had not been aware of the significant failings at the care home and risks posed to people's safety. The provider appointed an interim manager, following our communication with them.
● The provider made the decision for the care home to close during our inspection. This was robustly supported by daily presence of the local authority, and health and social care professionals, to ensure people could move, and their care needs could be met. The interim manager ensured people had appropriate access to healthcare professionals for care and health assessments to take place. On 13 March 2023, all people had been supported to move to alternative care providers.

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 did not consistently evidence their commitment to, and understanding of, the duty of candour. We found examples whereby appropriate communications had not taken place with people's representatives, the local authority and CQC. This was further evidence to us of a closed culture operating at the service which was not transparent and open.
● 1 representative told us they had not been informed of important events which concerned the health and well-being of their relative, and further said, "I feel there is no transparency".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had not carried out appropriate quality assurance reviews. The registered manager shared a quality exercise they said had been completed in 2022, however, representatives could not recall being approached to provide feedback.
● Representatives said they received mixed communications, and often these communications did not result in actions. For example, representatives said meetings were not arranged as discussed, and newsletters were infrequent.