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Beeches Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Beeches Care Home is a residential care home, providing accommodation for persons who require nursing or personal care. The service provides support for up to 40 people including older people, younger adults and people living with dementia. At the time of our inspection there were 27 people using the service.

The property was set over 2 floors with lift access to the upper floor. There was a communal dining room and lounges, a shared shower room and accessible rear courtyard.

People's experience of using this service and what we found
The provider did not have adequate systems and processes to monitor and manage fire safety, health and safety or infection prevention and control (IPC). Staff deployment was not always effective. We received feedback about low staffing levels and the impact this had on safety and quality of care. Recruitment and medicines were not managed safely. The provider failed to learn from incidents, accidents and safeguarding concerns.

People were not always supported to have maximum choice and control of their lives and staff did not always 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.

Care records were detailed, though we found some inconsistencies with information and people did not always get the care they needed. Records we reviewed raised concerns around people's fluid intake, and we received mixed feedback about the food. Staff had an induction and training was refreshed annually, but they did not receive periodic supervision to monitor competence. The home required maintenance and refurbishment and was not fully adapted to meet people's needs.

People and their relatives were not always consulted when planning or reviewing care and treatment. We observed caring interactions and staff spoke about people with dignity and respect, but staff did not have time to talk with people and care could be task focused. A person living at the home told us, "The staff are a lovely group of people, but they don't always have enough time to give us their full attention."

There was a lack of meaningful activities, and people did not always receive personalised care in a way that met their preferences. People had limited opportunities to express their views around the quality of care and appropriate action was not always taken in response to concerns. Complaints were not analysed to help prevent reoccurrence. Staff did not receive training around end-of-life care and information about people's advanced wishes was missing from care records.

The provider and registered manager had not maintained good standards. Systems to monitor the quality of care were not utilised and audits had not picked up some of the issues identified during inspection. Action was not taken in a timely manner to resolve issues or drive improvement. Systems and processes failed to

engage people, their relatives or staff and promote good outcomes. Staff worked hard as a team and people generally spoke about them positively.

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 21 April 2021)

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk and safe care and treatment. This inspection examined those risks.

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

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

Enforcement and Recommendations
We identified breaches in relation to person-centred care, safe care and treatment, premises and equipment, good governance and staffing. We made recommendations in relation to learning lessons when things go wrong, receiving and acting on complaints and consent.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Beeches Care Home

Detailed findings

Background to this inspection

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

Inspection team
Two inspectors and an Expert by Experience took part in the inspection process. 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
Beeches Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Beeches Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from professionals at the local authority who had been working with the service. We used 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 the inspection we spoke with 6 people living at the home and 9 relatives about their experience of care provided by Beeches Care Home. We spoke with 15 members of staff including a partner, the registered manager, the compliance and quality manager, an administrator, kitchen staff, a housekeeper, nurses, senior care workers and care staff. We observed people's interactions and the care they received. This helped us understand the experience of people with limited communication.

We observed medication administration and checked medication storage and recording systems. We reviewed a range of records including 7 people's care records and recruitment information for 5 staff.

We looked at records relating to health and safety such as fire safety information, testing records and servicing documents. We checked the environment, equipment, facilities and cleanliness; to assess if the home was safe and fit for purpose.

We remotely reviewed information relating to the management of the service such as policies and procedures, audits, meeting minutes, complaints and training. We sought additional evidence and clarification from the management team via email and telephone.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

● There were concerns around fire safety. Issues relating to ineffective fire doors were raised by Lancashire Fire and Rescue Service in December 2022, but action had not been taken to rectify this. Periodic safety checks had not been carried out consistently as per the home's policy. Extinguishers had not been serviced in over 12 months to ensure they would operate effectively in the event of a fire.

● There were not enough competent staff to manage an emergency evacuation safely; putting people, visitors and staff at risk of avoidable harm. The home did not currently have any trained fire marshals to lead an evacuation and drills had not been carried out with all staff. There was equipment available to move people downstairs should it be required in an emergency, but staff were not appropriately trained to use this. Guidance available had not been reviewed and some information was outdated.

● Risks to people were not always reassessed when their needs changed. One person had not had pressure care risk reviewed; despite evidence their condition was worsening. Another person's diet had not been reconsidered though they struggled to chew food.

There was a failure to ensure appropriate systems and processes were in place to assess, monitor and manage fire safety or risks to people's health and wellbeing. This put people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risks to people's health and safety were not always managed. Staff informed us that requests made for aids, adaptions or equipment were delayed and sometimes refused. A relative said, "[Person's] chair is not right for her. I have spoken to them, but nothing happens." Audits from September 2023 detailed a number of maintenance actions which were still outstanding; awaiting a decision or appropriate resources from the provider. Please see the responsive and well-led section of this report for more details.

● Several safety checks had not been consistently completed. This meant risks relating to premises and equipment were not monitored in line with the provider's own procedures.

Systems and processes had not been established to ensure health and safety risks were monitored and managed, putting people at risk of avoidable harm. 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

● A dependency tool was used to calculate staffing levels based on the number of people living at the home and their needs. However, we received consistent feedback that there were not always sufficient numbers of staff deployed. One person said, "Sometimes I wait a long time for assistance, and I would fall if I tried to

move myself. There are not enough people working here."
● When reviewing the electronic recording system 'Person Centred Software' (PCS) on 28 September 2023, 4 October and 23 October, there was a number of missed care tasks; indicative of inadequate staffing.
● When asking staff about the impact of current staffing levels; they told us people did not get sufficient support at mealtimes, they struggled to oversee people at risk of falls and managing accidents and incidents could be, "A stretch." Some staff did not have enough time to read care plans and risk assessments.
● Due to staffing numbers, people did not have their social needs and preferences met which was a risk to their mental health and wellbeing. One person said, "The one thing I lack is stimulation. I enjoy certain activities but there is not always anyone around to assist me. I would really enjoy some regular company." Please see responsive section of this report for more details.

There was a failure to ensure sufficient numbers of staff were deployed to meet people's needs. This put people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● Staff recruitment was not always safe. We found 2 application forms missing the relevant information around employment history and there was nothing recorded to confirm this had been investigated.
● The provider did not undertake appropriate checks to ensure existing staff were safe to continue working within the service. Two longer standing members of staff did not have DBS checks on record. We were informed the team should complete annual self-declaration forms as per company policy, yet these had not been carried out since 2018. Disclosure and Barring Service (DBS) checks provide information including details of convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes had not been established to maintain recruitment records and ensure compliance. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not managed safely. Staff administering medications had not had their competence assessed annually, as per guidance. The provider could not present records to evidence nurses and senior care workers had their competency checked within the last 12 months.
● We checked bottles of liquid medication for 5 people; none had been dated upon opening to ensure they could be discarded in line with manufacturer recommendations. This increased the risk of people being given ineffective or spoiled medicine which could cause adverse reactions or contribute to ill health.
● Room and fridge temperatures were not always in line with recommendations. Checks had been consistently completed. However, there were several occasions where the room and fridge temperatures were outside of the stipulated ranges and no action had been taken to address this.
● There was a large box of medication on the floor of the medication room. When enquiries were made it was identified the medication was due to be returned to the pharmacy. Records had not been completed to reflect this, posing risk of misappropriation.
● 'When required' medication records were not always completed with full details around variable doses. Three records checked had not been reviewed in line with guidance, to assess people's continued need or the effectiveness of their medication.

There was a failure to ensure appropriate systems and processes were in place for managing medications. We found no evidence that people had been harmed, however this is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The home had systems for the safe handling, storage and disposal of controlled drugs and records we reviewed were completed clearly.

Preventing and controlling infection
● We were not assured the provider was promoting safety through the hygiene practices of the premises. We received negative feedback from relatives. One relative said, "I don't think the home is clean, but the housekeepers do try." Several staff told us they were concerned about cleanliness and hygiene around the home. An action plan was shared with us following inspection in response to some of our concerns.
● During inspection we observed areas of the kitchen where dirt and debris had not been cleaned. A kitchen assistant was employed for 3 hours per day, but it was evident this was not sufficient to ensure a robust cleaning schedule could be maintained.
● Cleanliness of communal areas and equipment was not maintained. The shower chair in the upstairs shower room and the floor around 1 of the downstairs toilets were unsanitary. On both visits the upstairs shower room was left untidy; people's personal toiletries were not returned to their bedrooms and there was a pool of stagnant water on the floor resulting in a musty smell.
● Large sections of painted woodwork throughout the home were chipped and scuffed making thorough cleaning difficult.
● Two hazardous waste bin lids did not operate with the foot pedal, presenting a heightened risk of cross contamination.

Systems and processes had not been established to ensure cleanliness and hygiene were maintained. This put people at risk of harm. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● People were at increased risk of harm as systems for monitoring and learning from incidents and accidents were not robust.
● In a discussion with the provider and compliance and quality manager, it was acknowledged there was a lack of analysing incidents, accidents and safeguarding to help prevent events reoccurring. There was no clear information given about how or when processes would be introduced to improve this.

We recommend the registered manager reviews systems and processes used to analyse incidents and accidents and improve their approach to lessons learnt.

Systems and processes to safeguard people from the risk of abuse
● Not all staff had received up to date training in safeguarding awareness, though those we spoke to knew how to identify and escalate concerns.
● The provider had policies to guide staff on how to report concerns of neglect or abuse. Contact information for the local safeguarding team was displayed in the reception area for ease of access.

Visiting in care homes
● There were no restrictions on people receiving visits at the time of inspection.

Requires Improvement

Is the service effective?

Our findings

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

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

- Though assessments had been carried out and care records were in-depth, information was sometimes conflicting. For example: welfare checks, positional turns, continence care, mobility and bed rails. This may have caused confusion for staff and impacted safe care and treatment.
- People were not always receiving care in line with their assessed needs. A relative said, "[Person's] care plan looks really good, but I am not convinced it is read by staff or carried out." When accessing the PCS system throughout inspection missed tasks were noted including; safety checks, oral hygiene and application of creams.
- Adequate fluids were not always offered. Care records stipulated a minimum of 1500mls per day was required, though on several occasions the amount offered and/or drunk was much lower. One relative told us, "My issue is the lack of support with fluids. I find I need to continually ask for a jug of juice for [person]." People were not protected from the risk of dehydration.

There was a failure to provide care and treatment in line with people's assessed needs or respond appropriately to changing needs. This put people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- Feedback about food was mixed. Some people said the food was ok, others commented that food was not always hot and there could be a lack of choice. Portion sizes had recently been increased in response to feedback and fresh produce was available to ensure meals were more nutritious.

Staff support: induction, training, skills and experience

- Staff did not always feel well supported. The provider was not following its own procedures regarding frequency of staff supervision and appraisal. There was a lack of evidence of periodic 1 to 1 staff supervision and negative feedback had been received around this in staff surveys.
- The cook, a housekeeper and 2 bank staff did not have up to date training in key subjects relating to their roles. For example: food hygiene, control of substances hazardous to health (COSHH), infection control, moving and handling and safeguarding.
- The provider failed to adequately train staff supporting people during end-of-life, to ensure they could provide compassionate care in line with guidance and best practice. Please see the responsive section of this report for more details.

There was a failure to provide appropriate support and ensure suitably competent and skilled staff were deployed to meet people's needs. This put people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● Nurses commented positively about the registered manager and the assistance they provided to seek additional training as and when required.

Adapting service, design, decoration to meet people's needs
● The service was not fully designed or adapted to meet people's needs. Dementia friendly signage was poor and in some areas of the home did not exist. Appropriate signage can help support independence and wellbeing for people living with dementia. Some signage, such as the activities timetable were not reflective of what was actually happening which could be disorientating for people.
● There was a lack of ongoing maintenance and refurbishment to ensure the home was kept updated, welcoming and safe. This was due to reduced maintenance personnel and delays in decision making by the provider. One staff member said, "As a group, staff are frustrated with the state of the home. There's nothing inviting about the home and things are breaking all the time."
● The home had 2 baths which had hoists to assist people who were unable to climb in and out safely. Both hoists had been declared unfit for use and had not been repaired. This rendered the baths inaccessible and restricted choice for several people, the therapeutic benefits of bathing could not be enjoyed.
● The dining room experience was lacking and was not encouraging good social interaction or improved nutritional intake. Concerns were identified on the staff meeting agenda dated 17 January 2023 but action had not been taken to make improvements.

There was a failure to ensure premises were suitable for the purpose which they are being used and properly maintained. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During our visit, we observed people had personalised bedrooms with their own belongings.

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

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

● The service was not fully working within the principles of the MCA. People had mental capacity assessments completed for specific decisions. However, in files we reviewed there was a lack of information around who had been involved in decision-making; to evidence appropriate processes had been followed.
● People were not always consulted about their care. One person said, "Staff make the decisions."

We recommend the provider seeks guidance from a reputable source around MCA processes and takes the appropriate action.

● People who lived with an impairment of the mind or brain had been assessed for any potential restrictions to their liberties in line with DoLS. We were assured that appropriate authorisations had been applied for.
● Detailed care plans were available to guide staff around people's mental capacity.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to access healthcare services as and when this was required. Weekly ward rounds had been ongoing for several months and the registered manager commented these had been working well. One person told us, "If we need an appointment the staff make them for us."
● Information about input from health and care professionals was noted in the communication book and cascaded to the team in daily handover meetings. Details were included in people's care records.
● We received positive feedback from other agencies that they were contacted if necessary. One professional said, "Staff have been great contacting me on [person's] request or querying any issues or concerns."

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
- There was no evidence to show that people were consulted in the planning of their own care and treatment. One person said, "I don't really get a say in my care."
- Relatives were not always involved in reviews. Staff we spoke to confirmed relatives would not usually be contacted for their input.
- Relatives were not always included or kept informed regarding decisions about care and treatment. During a meeting with relatives in October 2022, concerns were raised around the lack of regular communication. A relative told us, "Sometimes I feel communication with me could be better. I am not always informed when mum has seen the doctor," indicating this had not improved.

Systems and processes had not been established to seek and act on feedback from relevant persons. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some people had been referred to advocacy services for support with making decisions about different aspects of their lives.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity
- Due to time restraints, staff were sometimes more focused on tasks rather than people and their wellbeing, and were not always able to consider what people wanted. One staff member said, "We can't give people what they need, it's like a conveyor belt. We rush from 1 person to the next so everything can get done."
- People were generally treated with dignity. Staff were courteous to people and respected their privacy. During inspection, we observed staff knocking on people's bedroom doors and calling out before entering.
- We observed staff to be kind and caring. When asked what they thought of staff, 1 person said, "The staff are very kind to me."
- Staff spoke about people with affection and respect. Staff told us they worked hard to provide good care despite the challenges they faced. A staff member said, "I love working here, I love the residents and looking after them."
- People's individual characteristics were considered. There was information in people's care records around their likes and dislikes and most staff we spoke to knew people well.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

- Staff did not have time to talk with people. One staff member said, "When I first started here, we had more time to speak with people. It has impacted people; they get a bit bored and can't understand why you can't spend time talking to them. It affects staff morale, it's more rewarding when you have time for people, I do miss that."
- There was little evidence of regular, meaningful activities. The activities coordinator was absent, and few adjustments had been made. Staff did not have the time to lead activities in their absence or support people to engage. A relative said, "Other than the occasional entertainment, there is a lack of activities." We reviewed activity charts between 26 September 2023 and 22 October and very few activities were logged, aside from 'grooming'.
- Those people who were cared for in bed had limited opportunity for social interaction. One person told us, "Because I am in my room most of the time, I eat alone. I know staff don't have time to sit with me, but company would be nice."
- Most staff we spoke to said they would not want a relative living at the home, in part due to the lack of activities. One staff member told us, "The staff are fantastic and work so hard. However, [the home] needs more soul, it's just awful. It needs more staff and more activities."

There was a failure to ensure personalised care and support which reflected people's emotional and social needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The home had made links with the local school. Earlier in the year, they had taken part in a zoom call for 'Lancashire Day' and joined students for events at the local library.
- People had recently been supported to practice their religious beliefs with blessings being held at the home. Christmas, Easter and other religious festivals were celebrated.

Improving care quality in response to complaints or concerns

- There were limited opportunities for people to express their views and drive improvement around the running of the home. Resident surveys had not been carried out in 2023 and only 1 resident meeting was documented.
- People and their relatives told us that things would not always improve if they raised a concern. A person living at the home said, "I do voice my issues, but I don't think anyone listens. Nothing changes."
- The provider has processes to log complaints on their system and provide written responses if required, but there was no system to identify themes and trends and prevent reoccurrence.

We recommend the provider improve systems and processes used to seek feedback and act on complaints and concerns.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People and their relatives were not always involved in planning or reviewing care, to ensure needs were met in a way they chose; and staffing restraints meant people could not always have their preferences fulfilled. Please see the caring section of this report for more details.

● A detailed 'this is me' document informed staff about people's history and what was important to them. A relative told us, "Staff asked about [person's] background before they moved in, to get an understanding of who they are."

● Records had been reviewed when people's health and care needs changed.

End of life care and support

● Staff did not receive adequate training to enable them to understand the care and support needs of people during end of life.

● Death and dying care plans were in place. However, those we reviewed did not include details of people's advanced wishes. For example: whether they would prefer to be buried or cremated, funeral arrangements or after death care.

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.

● Care records contained detailed assessments and information about people's level of communication.

● There was some information around the home displayed in picture format, to support people who could no longer read.

Inadequate

Is the service well-led?

Our findings

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

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

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

- The provider and registered manager were aware of their roles and responsibilities, yet had not maintained good standards. Guidance, best practice and the provider's own policies and procedures were not always followed.
- The provider did not have adequate systems to monitor the quality of care provided and drive improvement. The PCS system highlighted and alerted managers to missed care tasks, but this function was not being utilised to monitor or improve people's care and treatment.
- Various charts were available on PCS to record fluid intake, positional turns, oral hygiene and activities etc. In records we reviewed, they were not consistently completed in line with people's care needs. Care plan audits lacked relevant prompts and we saw no evidence of other systems used to manage this.
- There was no structured and systematic approach to assess and monitor the service. Audits had recently been streamlined so we were only provided copies from September 2023. Those reviewed had not identified and resolved concerns raised during inspection, for example: medication and infection prevention and control. Systems were not embedded.
- Systems and processes were not consistently applied or effective at managing health and safety risks and action was not taken in a timely manner. Fire safety checks were supposed to be carried out weekly, but these were dated; 27 September 2023, 17 August 2023 and 20 November 2022. The most recent 2 checks identified fire doors were not closing fully rendering them ineffective. The provider was aware of these concerns, yet action had still not been taken.
- We found inconsistent and incomplete information in records relating to people's care and treatment. Care records had been reviewed but issues identified during inspection had been missed, showing a lack of oversight.
- Systems failed to promote person-centred care and people's outcomes were negatively affected as a result. One relative told us, "[Person's] quality of life has definitely deteriorated because of a lack of good care."

Systems and processes had not been established to effectively assess, monitor and improve the quality and safety of services. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were positive about the registered manager. One staff member said, "I feel [registered manager] is

supportive and very approachable. They try their best to help." Staff confirmed they felt able to raise concerns.
● Staff told us they generally liked working at the home and everyone worked well as a team. A staff member told us they enjoyed working at the home because of their colleagues and the people. Another added, "We are a really good bunch."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We were told by a number of staff their ideas for improvement or requests made would be escalated to the provider, but would often be delayed or declined. One staff member said, "A lot of times, staff feel like what's the point and become frustrated when requests are denied."
● Processes were not in place to routinely involve people and their relatives in planning their care or improving the service. There was evidence of some communication and attempts to gain feedback but the approach was not consistent.
● Surveys had been sent to relatives earlier this year so they could express their views. However, there was a lack of evidence to show analysis had been completed, to determine how feedback was used to drive improvement.

There was a failure to seek and act on feedback from relevant persons. Systems and processes had not been established to effectively listen to, record and respond to feedback. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood their responsibility in relation to the duty of candour. Systems were in place to report certain incidents or safeguarding concerns.

Working in partnership with others
● During our visit the registered manager spoke about how the home worked closely with different professionals. For example: the dietitian was kept informed following concerns with people's weights.
● Community connections had been developed with the local school, childminding groups, library and church.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Providers must do everything reasonably practicable to assess people's care and treatment needs and preferences, including those relating to emotional and social needs. There was a failure to ensure people could access and engage in meaningful activities and benefit from social interaction. 9(1)(2)(3)(a)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Providers must do all that is reasonably practicable to fully assess, monitor and manage the health, safety and welfare of people using the service. Systems and best practice guidance were not followed around risks relating to fire safety, safe care and treatment and hydration. Medicines were not managed safely. 12(1)(2)(a)(b)(d)(g)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Providers must ensure all premises and equipment used by the service is clean, suitable for the purpose for which they are being used and properly maintained. There was a failure to ensure a good level of cleanliness and there was not suitable arrangements for the maintenance of premises and equipment. Dementia friendly signage did not take into account best practice guidance 15(1)(a)(c)(e)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes must be established and operated effectively. Procedures for governance

Treatment of disease, disorder or injury	and oversight of quality, safety and recruitment were not effective, and there was a failure to seek and act on feedback. Accurate, complete and contemporaneous records were not maintained. 17(1)(2)(a)(b)(c)(d)(e)(f)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified and competent persons must be deployed. There was a failure to ensure sufficient levels of staff were deployed to meet people's care and treatment needs and keep them safe. Training and competence was not reviewed at appropriate intervals. 18(1)(2)(a)

The enforcement action we took:

Warning notice