Hewitt-Hill Limited

Church Farm Care Home

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
Church Farm Care Home is a residential care home providing personal care and support to up to 40 people. The service provides support to people aged 65 years and over, many of the people were living with dementia. At the time of our inspection there were 36 people using the service. Care is provided across 2 floors, with communal spaces including bathrooms and lounge areas, there is a people carrying lift in place.

People's experience of the service and what we found:
People were not living in a well maintained care environment, with many surfaces and items of furniture damaged, impacting on the ability of staff to keep them clean. People were not being supported by sufficient numbers of suitably trained staff, particularly at night time, increasing the risks relating to the ability of staff to meet people's assessed needs, including in the event of an emergency such as a fire.

The oversight and management of people's individual risks in relation to their pressure care, food and fluid intake, falls management, diabetes care, mental health and wellbeing and bowel monitoring was all found to be poor. People were at risk of accessing items such as denture cleaning tablets, drink thickening powder and personal care products including razors, without staff supervision. This was of particular risk for those people living with dementia who were reliant on staff to maintain their safety.

People were not receiving their medicines safely, with poor oversight of medicines management by the registered manager and provider. The quality of audits and checks in place to provide high standards of care were ineffective. Where the provider's own audits had identified action needing to be taken, we found these were not addressed in a timely way to maintain people's safety.

Where people were involved in accidents and incidents this information had not been consistently reported to CQC in line with the registered manager and provider's regulatory responsibilities. Overall, the registered manager and provider did not have oversight of what accidents and incidents were happening at the service, due to a lack of reporting systems in use.

People were not always 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.

The service offered limited activities, did not foster inclusion for many of the people seated in the main communal lounge, and did not offer the standard of meaningful activities outlined in the provider's own statement of purpose.

People's levels of privacy and dignity were not upheld, for example when transferring people using equipment in communal areas of the service, or where people were receiving personal care in their bedrooms. People's continence products were left in large boxes in corridors, next to fire escapes and on

show in people's bedrooms, impacting on their privacy and dignity. People were observed to repeatedly ask staff for support to access the toilet and staff did not return in a timely way to meet their needs.

The service was not well led, and the new provider had not completed detailed audits and checks on taking over the ownership and accountability for the service. There were risks relating to closed cultures within the service, with staff morale found to be low, and many staff tearful when speaking with us.

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

Rating at last inspection
The service was registered with us on 14 July 2023 and this is the first inspection under a new registered provider. The last rating for this service under the previous provider was requires improvement (published 18 December 2019).

Why we inspected
The inspection was prompted in part due to concerns received about safe staffing levels, responsiveness of care and food quality. A decision was made for us to inspect and examine those risks.

Enforcement and recommendations
We have identified breaches in relation to safe care and treatment, provision of dignified care, the assessment and implementation of the Mental Capacity Act (2005), meeting people's nutritional and hydration needs, good governance and oversight of the service, and staffing levels.

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

Follow Up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well-led findings below.

Church Farm 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
On day 1 of the inspection, the team consisted of 3 inspectors and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On day 2 of the inspection, the team consisted of 2 inspectors.

Service and service type
Church Farm 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. Church Farm is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

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

Notice of inspection
Both days of the inspection were unannounced. Day 1 of inspection commenced at 6.30am to enable an inspector to meet with night staff.

What we did before the inspection

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about this service on our systems and liaised with the local authority to help us plan this inspection.

During the inspection
We spoke with members of staff including the registered manager, regional manager, deputy manager, 6 members of care staff including 2 that worked at night time, a member of kitchen staff and the activity coordinator. We spoke and interacted with 6 people living at the service and observed care provided in communal areas. We spoke with 4 people's relatives about the care provided.

We reviewed a range of records, including 11 people's care records and 9 medication records. We also reviewed monitoring charts for food, fluids, bowel care, repositioning and the application of creams on people's skin. We looked at 2 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We continued to seek clarification from the provider to validate evidence found, this included seeking assurances from the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We liaised with the local authority quality assurance team, requested for a referral to be made for the service to receive support from the medicine optimisation team, and made referrals to the safeguarding team, due to the level of risk and concern identified at this inspection.

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 under the previous provider 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

- The provider did not assess risks to ensure people were safe. Staff did not take action to mitigate any identified risks.
- People's individual risks, care and support needs were not thoroughly assessed. Where staff lacked information, this was not sourced for example from the GP, to ensure staff could safely meet people's needs.
- People's skin was at risk of deteriorating or developing pressure sores, as people were not being supported to change position regularly. Corresponding repositioning records contained gaps and were poorly completed.
- People were at risk of accessing, and consuming items including denture cleaning tablets, drink thickening powder, personal care products such as razors, which were being stored in the same cups as tooth brushes. This was of particular concern for those people living with dementia, reliant on staff to keep them safe.
- Where people had experienced falls, staff were not following their own post falls head injury monitoring processes in place for 48 hours after the fall. Records repeatedly showed the checks were ceased part way through the first 24 hours, without confirmation from a health care professional it was safe to do so.
- Oversight of people's bowel care was poor. Records contained many gaps. This had resulted in a person becoming extremely unwell and needing to be treated in hospital.
- The quality of information shared between staff at their shift handover meetings was poor. The level of information did not cover individual risks and did not ensure staff unfamiliar with people's needs were aware of all relevant information to meet their needs and risks.

The provider did not mitigate risks to people receiving care. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- People were not supported to receive their medicines in a safe way.
- People were not consistently receiving their medicines on time, with medicine rounds taking a long time to complete.
- We identified medicine errors, including stock level discrepancies and issues around safe storage of medicine when being cut in half by the service. Overall, the medicine room was found to be untidy and disorganised.
- Staff were not keeping a record of people's stock levels, particularly where they could give people a variable dose of their medicines, to ensure the dosages were being monitored, and medicines accounted for.

● Records for topical medicine applications such as creams and ointments contained gaps, which did not ensure people's skin was being well cared for.
● We identified security and storage concerns where people could access medicines. Prescribed creams were not being stored securely in people's bedrooms. We found times where the medicine cabinets were left unlocked in communal areas of the service, with no staff present. We identified 1 of the medicine cabinets did not lock securely as the locks were damaged.
● Where people were asleep when staff attempted to give them their medicine, records did not show additional attempts were made to ensure the medicine was taken. This resulted in people missing large amounts of their medicines. The service had not sourced advice around this risk from the GP.
● Protocols for medicines to be administered 'as required' lacked required details to ensure this type of medicine was appropriately used and the guidance was clear for staff on when to contact the GP for advice or intervention. People's allergy information was not being recorded on each medicine administration record sheet to ensure associated risks were not overlooked.

Risks relating to the management of people's medicines were identified. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our request, the service completed a full audit of each person's medicines. Multiple issues were identified and reported to the local authority safeguarding team.
● On day 2 of our inspection, we observed the damaged lock on the medicine cabinet was being replaced.
● Most people felt they received their medicines within reasonable timescales, a person said, "Medicines are usually pretty good, within the hour anyway."

Staffing and recruitment
● The provider did not always ensure there were sufficient numbers of suitable staff.
● Staffing numbers, particularly at night time were not sufficient to meet people's assessed needs and risks. There were not enough staff to support people at night in the event of an emergency such as a fire. Our findings were reinforced by feedback, a person told us, "Mostly there is staff to help except when they are busy." Another person said, "I do not think there are enough staff at night if I am honest." A person's relative told us, "When we are here, if we need anything, we go and fetch someone." Another relative told us, "There are less staff in the evening and overnight which concerns us."
● A high number of people required repositioning, and support with personal care tasks overnight. Some people did not sleep well or spent time in communal areas of the service overnight. Care was provided across 2 floors, with insufficient numbers of staff to effectively monitor and meet people's needs.
● A dependency assessment tool was in use, but this lacked detail of how people's levels of dependency were calculated and was not an accurate reflection of where people's needs had increased due to changes in their levels of health and care support needs.
● The provider's records showed staff had not completed many mandatory training courses. This did not ensure staff had the required training, knowledge, and skills to meet the requirements of their roles. Agency staff were being used to cover staffing shortages, we received feedback from a relative stating, "Things have definitely changed since the new owners took over. Things just do not feel quite the same and its noticeable agency staff are being used now."
● We observed people to repeatedly ask for support to access the toilet, and staff did not return to assist them. A person told us, "I often need the toilet at 11am and again at 3.30pm and these seem to be the times they [staff] get busy." We activated a person's call bell as they had slid out of bed, and their call bell was out of reach. We were told by the staff member who responded the person did not listen to their advice about using the call bell and indicated the person had intentionally slid out of bed to source staff attention.

Sufficient levels of suitably trained, competent staff were not in place to keep people safe, in line with the service's own assessed staffing numbers. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider operated safe recruitment processes. Staff files contained pre-employment safety checks, reviewed any gaps in applicant's employment histories, and ensured staff were safe to work with vulnerable people.
● Following our inspection, we received assurances from the provider that changes to staffing levels, including at night time had been put in place, in response to our feedback.

Systems and processes to safeguard people from the risk of abuse and avoidable harm
● People were not safeguarded from abuse and avoidable harm.
● The service was not following local safeguarding guidance in relation to the reporting of falls and medicine errors.
● Poor oversight of accidents and incidents resulted in inconsistencies in onward reports to the local authority safeguarding team and to CQC, to protect people from the risk of harm.
● We identified a person newly admitted to the service was expressing the wish to harm themselves, but no additional welfare checks, or safety measures were implemented to protect and support that person.
● Avoidable harm was identified, which resulted in an admission to hospital, due to poor oversight of the person's basic care needs.

Preventing and controlling infection
● People were not always protected from the risk of infection as staff were not consistently following safe infection prevention and control practices.
● Areas of the home and items of furniture needed to be refurbished or replaced. Surfaces were no longer intact, impacting on the ability for staff to keep these areas clean and prevent the spread of infection. Some items of furniture and areas of flooring were visibly stained.
● The provider's training matrix showed a large number of staff had not completed required infection prevention and control training or a refresher course to ensure they had the required knowledge and skills to meet the requirements of their individual roles and keep people safe from the spread of infections.
● Staff were not following basic hygiene standards to prevent a person with a catheter from developing an infection. The catheter bag was in contact with the floor carpet, rather than being kept on a stand while they were in bed.
● Staff were not following the provider's dress code policy to manage infection control risks. Staff were observed to wear jewellery, nail varnish and have long nails while responsible for providing hands on care.

Visiting in Care Homes
● People were able to receive visitors without restrictions in line with best practice guidance.
● There were no restrictions in relation to visiting people living at the service, with the option for relatives and friends to stay for meals. People and their relatives confirmed this, with 1 person telling us, "I have visitors too and at the weekend my [close relative] is hiring a wheelchair taxi for us to spend the day out. We are going shopping, I am really looking forward to it."

Learning lessons when things go wrong
● The provider and registered manager did not demonstrate lessons were being learnt from or acted on in response to feedback given between day 1 and 2 of inspection, or after our inspection visits.
● A lack of records, and poor oversight of accidents and incidents at the service did not foster an environment of shared learning and reflective practice in response to where improvements were required.

● Morale within the staff team was poor, which impacted on staff confidence to speak up and raise concerns or admit where mistakes may have occurred.

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 under the previous provider 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.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

- People were not supported to eat and drink enough to maintain a balanced diet. People were not supported to live healthier lives, access healthcare services and support.
- People's dining experience was poor. Breakfast continued to be served until 11.45am, and lunch took more than 2 hours for each person to be served. People were not served in groups, so everyone ate at different times, resulting in some people getting up and leaving as no longer wishing to wait.
- Food and fluid records were poor. On paper these showed some people had not eaten anything within a 24-hour period, and 1 person's records showed they had not consumed anything for 3 days.
- Where there was specific guidance, for example from a dietician, about snacks, or the number of drinks people should be offered within a 24-hour period, this guidance was consistently not being followed.
- Where people's weight needed to be monitored on a weekly or monthly basis due to the risk of loss, we identified gaps in the completion of these records. Staff recorded judgements on the stability of people's weights when there were considerable gaps between weights being checked, this did not ensure this information was accurate.
- People's records contained statements like, 'weight remains stable' when the records showed fluctuation in weight recorded. We noted a person had been newly admitted to the service, and their records showed no weight check had been completed after a week of living at the service.
- Areas of people's care such as the management of their weight, nutritional intake and exercise levels were poorly monitored. People were not supported to lead healthy, active lives.

Risks relating to the management of people's nutrition, hydration, weight and health were poorly managed. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Overall, we received positive feedback about the quality and choice of food available.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)

● The provider was not working in line with the Mental Capacity Act.

● People's records did not consistently contain capacity assessments. Where assessments were in place, these were not decision specific in line with the Act (2005).

● Staff demonstrated a lack of understanding in relation to giving people their medicines in food, and the difference between choice, and where a mental capacity assessment and best interest decision would be required.

● Where people's records contained best interest decisions, there was no record of feedback sourced from other health and social care professionals, or people's relatives, only details of the assessor were recorded.

● Whilst important to ensure people's relatives were fully consulted in the assessment process, assessments did not contain confirmation of whether those relatives held legal authority to make decisions.

● Closed circuit television was in use within communal areas of the service. People's care records did not contain details of capacity assessments to determine their ability to consent to this form of monitoring being used. This did not demonstrate the service was adhering to the provider's policy.

● The service have been unable to provide a DoLS log, or details of any audits they were completing to ensure oversight of any conditions relating to DoLS in place. Not all staff had completed MCA and DoLS training to develop their knowledge and understanding of this area of care.

The provider was not ensuring staff were adhering to the Mental Capacity Act (2005) or DoLS in their practice and approach to people's care. This was a breach of regulation 11 (Need for consent) 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

● People's needs were not assessed, care and support was not delivered in line with current standards. People did not achieve effective outcomes.

● We identified a lack of key risk information being gathered prior to people being accepted and moving into the service. This did not ensure staff were clear of people's needs, and whether these could have safely been met. This included in relation to the management of long-term conditions such as diabetes care.

● Action to address the risks associated with gaps in information were only addressed at our request and not due to the provider's own audits and safety checks identifying risk information was not being gathered to inform people's care and support needs.

● The lack of detailed preadmission assessments being completed, also resulted in consideration not being given to the impact of new people moving into the service, in relation to the needs and dynamics of those existing people already living at the service.

● People's care was not person-centred and lacked independent choice and control over their daily routines. Care was task based, and dependent on staff availability. As a result people did not get to choose basic aspects of their care such as when they got up or ate their meals.

● Staff were not supported to work in line with the provider's vision and values for the service, as outlined in their statement of purpose. People did not have individual goals and aspirations outlined in their care records to achieve good care outcomes.

● Recognised assessment tools were not in use for areas of care including pain and the management of constipation, medicine management and reducing the use of medicines that impact on people's wellbeing and abilities.

The provider was not ensuring people received personalised care, tailored to their individual wishes, needs and preferences. All of the above was a breach of regulation 9 (Person-centred care) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The service did not ensure staff had the skills, knowledge and experience to deliver effective care and support.
● Staff consistently told us they did not feel well supported since the service's registered provider had changed.
● The provider's training matrix showed staff compliance and completion rates of mandatory training to be poor, we could not be assured staff had the required training, skills and knowledge to meet people's needs safely.
● Staff were not receiving regular supervision, and no staff had received a performance appraisal. This did not ensure the provider or registered manager had good oversight of staff individual performance, or identification of learning and development needs.
● We identified a lack of competency assessments in place, and quality checks being completed by the registered manager, to ensure staff understood the requirements of their role, such as administering people's medicines.
● The service relied on use of agency staff to cover staffing shortages. We identified a lack of detailed information being given during shift handover meetings and in people's care records to ensure agency staff were able to support people effectively.

Sufficient levels of suitably trained, competent staff were not in place to keep people safe, in line with the service's own assessed staffing numbers. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care
● The provider did not ensure the service worked effectively within and across organisations to deliver effective care, support and treatment.
● We identified poor standards of communication and escalation of risk within the staff team and with external professionals. Poor records further impacted on recognition of risks and when escalation such as to the GP or emergency healthcare professionals was required.
● We observed a visit from a healthcare professional. All checks were completed in the communal lounge, impacting on people's privacy and confidentiality. This included people newly admitted to the service, which did not place people at ease or support them to speak openly.
● Care records did not demonstrate collaborative working and joint management of risk between people, their relatives, staff and or external health and social care professionals to achieve good outcomes.
● Due to a lack of personalised detail in people's care records, there was no clear guidance in place for staff to follow support people for example with attending medical appointments.

Adapting service, design, decoration to meet people's needs
● People's individual needs were not met by the adaption, design and decoration of the premises.
● The service was not designed to aid those people living with dementia to orientate themselves within the care environment.
● The overall condition of the care environment was poor, and in need of redecoration to make people's living environment clean and comfortable.
● Most people's bedrooms were personalised, containing items of personal importance.

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 under the previous provider we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not treated with compassion, kindness, dignity and respect.

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

- People were not well supported and treated with respect by staff.
- People's overall quality of life was poor, lacking choice and options to ensure people's wishes and preferences were maintained. Whilst staff were trying to support people, the lack of staff, routines and structures in place resulted in care being task focused, rather than personalised, and did not value the importance of treating people as individuals.
- Our findings were reinforced by feedback received. A relative said, "My concern is that valuable staff will leave and what the subsequent effect that will have on the home itself and the care of my [relative] does not bear thinking about, following the change in provider."
- People were not treated as individuals and were not empowered to pursue personal goals and objectives. People's care and corresponding records did not reflect value was placed on their protected characteristics, equality or diversity.
- We observed staff to have variable levels of knowledge of people's individual wishes and preferences. Choices available to people were limited, and staff were unable to spend quality time with people to build trust and caring relationships.
- People were not supported to develop relationships with their local community. There was limited external entertainment or visitors to enrich people's spiritual wellbeing, hobbies and interests.
- Overall, we received positive feedback from people and their relatives confirming the staff treat them with kindness. A person told us, "Oh yes, they [staff] are kind and caring enough." Another person said, ""All of the staff are good people." A person's relative said, "The carers are so approachable, it is a big family here."

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

People were not supported to express their views and make decisions about their care.

- People and their relatives were not being actively encouraged to provide feedback on the standards of care provided, development of people's care records, or on the day to day care provided.
- The provider team sent representatives new to their organisation, rather than meeting with people or their relatives, and were not completing regular visits to the service to source feedback and build working relationships with people, relatives or staff.
- The service confirmed they did not have a key worker scheme in place. This did not ensure that people had an allocated key worker (staff member) who they could share feedback with on a 1 to 1 basis, or get to know their needs and wishes on an individualised level.
- The provider level audit shared with CQC did not record any time taken to speak with people, their relatives or staff to source to source their feedback.

● Overall, people told us they felt their wishes and preferences were met. A person told us, "I will not have men. It would not be right, would it? No, they [staff] do not send me men."

Respecting and promoting people's privacy, dignity and independence
● People's privacy, dignity and independence were not respected and promoted.
● People's care was not personalised. Records did not contain accurate information to capture people's levels of independence and areas of their care where they required support or encouragement.
● Staff did not respond when we knocked on a bedroom door, to alert us to the fact they were providing personal care to a person on their bed, to protect the person's privacy and dignity.
● Where people required use of continence products, these were not stored privately, instead being located outside bedrooms in corridors, and not put away in their bedrooms to protect their dignity.

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 under the previous provider we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant people's needs were not met.

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

● People were not consistently receiving personalised, individually tailored care in line with their own wishes and preferences. People's opportunities to choose and have control over their daily routine were found to be limited.

● Care records did not contain evidence of people and their relatives where appropriate, being consistently involved in decision making relating to their care and support needs and wishes. There was also a lack of information for those people no longer able to express their wishes verbally to ensure their past wishes were upheld. We received mixed feedback from relatives in relation to reviewing people's care records, the feedback indicated involvement on admission, but less once the person was settled at the service.

● We observed people's call bells to activate and sound for long periods of time before staff were available to respond to their needs. The lunchtime meal required greater staffing allocation to ensure people received their meal within appropriate timescales.

Meeting people's communication needs

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

● The provider was not always meeting the Accessible Information Standard. People's communication needs were not always understood and supported.

● Where people's communication needs were changing, their communication care plans did not accurately demonstrate how this was impacting on their abilities to make staff aware of their support needs. A person told us, "The biggest problem for me is I wear hearing aids and I cannot always understand the staff when they speak to me."

● Use of poorly trained and unfamiliar staff posed a risk for those people with limited abilities to communicate to ensure their needs were recognised and met and they continued to be treated as an individual.

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

● People were not supported to maintain relationships, follow their interests or take part in activities that were relevant to them.

● The standards of activities observed were poor. We observed a number of people seated around a table, wearing aprons ready to participate in a baking activity, but the staff member completed all aspects of the

task. This did not ensure people had an opportunity to participate in a meaningful activity. Our findings were reinforced from feedback we received. A relative told us, "No I do not think there are enough activities." Another relative said, "There was a good selection when there was 2 activities staff - but 1 left and now it has all gone into decline."

● Where people chose to sit on the periphery, smaller 1 to 1 or group activities were not initiated by staff to foster engagement in activities or use the time as an opportunity to get to know more about what people would enjoy or wanted to have added to an activity programme.

● Music and television, as well as other environmental noise was a constant within the main communal lounge, which impacted on people's ease to communicate, but also to hear properly resulting in pockets of social isolation.

● We observed a person to be seated under the wall mounted television for the duration of day 1 of inspection. They were unable to see the screen properly but had the constant noise overhead. No consideration had been given to the position of this person's chair or offering of choice.

● Staffing shortages impacted on daily activity sessions as the activity coordinator was required to support with care tasks. This resulted in even less activities happening within the service.

● Activities and events in the service were photographed, videoed and posted on social media, which was not a closed account for the service. Records did not contain evidence of individual consent, and the handling of personal data had not been formally assessed.

The provider was not ensuring people received personalised care, tailored to their individual wishes, needs and preferences. All of the above was a 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 service have been unable to provide evidence of complaints and compliments received, or any evidence of the handling of complaints. We were therefore unable to ascertain if the service followed the provider's own complaints policy.

● Where we raised concerns directly with the provider regarding staff morale, and allegations of bullying raised with us during the inspection process, we were concerned by the provider's lack lustre to take action to respond to the concerns and welfare of their staff team.

● People and relatives told us they had not had reason to raise concerns with the service. A person's relative did tell us they had met with the provider's representative, and stated, "[Name] did not seem interested in the care and kindness that goes on here. They behaved rather like a salesperson and focused on things like flooring. We know they have upset staff and have been making many [staff] cry, which cannot be right. My concern is that valuable staff will leave and what the subsequent effect that will have on the home itself and the care of my [relative] does not bear thinking about."

End of life care and support

● There was no one receiving end of life care at the time of our inspection.

● The quality of end-of-life care planning varied. People's care records did not include details of their wishes and preferences at this stage of their care.

● The provider's training matrix did not demonstrate that staff received training in the provision of end-of-life care, or in relation to supporting people to have discussions and make plans for their future care needs to ensure their wishes and preferences were known.

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

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

- The condition and cleanliness of the service did not ensure good care outcomes for people. Staff lacked the required training and expertise to recognise people's individual support needs and risks, resulting in care, which was not safe or person-centred.
- We identified evidence of a closed culture within the service. We identified examples of accidents, incidents which had not been openly shared by the provider with external professionals and stakeholders.
- The provider demonstrated a lack of value placed on their staff team. There was a lack of support to ensure staff flourished, particularly those new to social care.

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 provided demonstrated a clear lack of recognition of their own regulatory responsibilities and accountability, including where things went wrong. The provider demonstrated a lack of engagement with the inspection process, and an unwillingness to be open and honest with inspectors. Instead most inspection related tasks were delegated, with a clear lack of oversight as to the standard and quality of responses provided.
- The provider demonstrated a lack of knowledge of people's individual risks and support needs, to ensure they provided a service that was safe and fit for purpose. Our findings were reinforced by feedback received, a relative told us, "It is potentially a lovely place to be. Caring and kind staff who work very hard. What needs improving is that the new owners need to listen to the staff, to try to keep them, and listen to the families and residents about the running of the home."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager and the provider demonstrated a lack of recognition of the need to take timely, robust action and provide assurances to address the seriousness of our concerns and findings.
- The provider's statement of purpose was not an accurate reflection of the standards of care provided at the service.
- The provider and registered manager did not recognise their individual regulatory responsibility to ensure they notified CQC of incidents and accidents at the service. This included where failings of care had resulted in avoidable admissions to hospital, incidents impacting on the safe running of the service, and a person

with unexplained bruising.
● Where audits were being completed, these were of poor quality, and did not identify where action needed to be taken, therefore did not drive safety and improvement at the service. Findings in audits did not reflect the risks and concerns found during our inspection.
● Provider level oversight of the service and staff performance was poor. They had not identified where staff were not adhering to their own policies and procedures.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We found limited evidence of engagement with people and their relatives by the provider on taking ownership of the service. Changes to staff culture within the service had been recognised by people's relatives. A relative told us, "The new owners are changing the culture of the place. Staff are leaving. People with dementia need familiar faces and continuity with their care."
● Areas of people's care records were generic, and did not contain key information or contained inaccuracies, impacting on the information available for staff to follow. Due to a lack of care record audits being in place, the provider was not identifying shortfalls and ensuring records were accurate and person-centred. Going forward, the provider was implementing the use of electronic care records, but a lack of consideration had been given to record keeping in the interim to maintain a safe service.

Continuous learning and improving care
● This inspection was in part completed due to concerns received about the service. Prior to our inspection, we had sourced additional assurances from the provider about the standards of care being provided, staffing levels, and quality of nutrition and hydration. The provider had sent us written confirmation that people's care needs were being met, with sufficient numbers of staff, and that monitoring was in place in relation to people's food and fluid intake. Inspection findings do not reflect the provider's previous assurances.
● Where accidents and incidents had happened at the service, there was no trend or thematic analysis being completed by the provider to learn from these events and to implement changes to reduce the risk of reoccurrence, mainly due to a lack of accurate records being kept.

Working in partnership with others
● The care provided demonstrated a lack of joint working with external health and social care professionals, as well as with people living at the service and their relatives. This resulted in poor care outcomes and missed opportunities to improve care standards.
● Prompt action was not being taken to source external professionals' guidance and feedback to ensure good outcomes for people.
● The provider was not sourcing timely external contractors and maintenance works to address the condition of the service. Where actions were identified, there was a lack of clear timeframes for improvements to be made to improve people's overall quality of life.

The provider had poor governance and oversight arrangements in place to maintain standards and drive improvement at the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care provider was not ensuring people received personalised care, tailored to their individual wishes and preferences. This was a breach of regulation 9 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The care provider was not ensuring staff adhered to the Mental Capacity Act (2005), and Deprivation of Liberty Safeguards to uphold people's rights. This was a breach of regulation 11(1).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care provider was not ensuring risks within the care environment, or standards of care provided were well managed. This included in the management of people's medicines. This was a breach of regulation 12 (1).

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider did not have good governance and oversight arrangements in place to deliver consistent standards of care or drive improvement. This was a breach of regulation 17 (1).

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The care provider was not ensuring there were suitable numbers of trained and competent staff on each shift to meet people's assessed levels of needs and risks. This was a breach of regulation 18 (1).

The enforcement action we took:

Warning notice.