Blue Mar Limited

# Colebrook Manor

## Inspection report

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Date of inspection visit:
02 September 2021
07 September 2021
08 September 2021
14 September 2021
15 September 2021
23 September 2021

Date of publication:
02 November 2021

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
Colebrook Manor is a residential care home providing personal and nursing care to 35 people aged 65 and over at the time of the inspection. The service can support up to 48 people.

People's experience of using this service and what we found
People living at Colebrook Manor did not receive a safe, effective and well led service. The registered provider had failed to ensure that monitoring and governance systems and processes were established and operating effectively to maintain people's safety and welfare.

The service did not have effective and consistent managerial and operational leadership. Staff were committed to providing good care, however, staff did not always receive adequate and effective support to ensure they could carry out their roles to the best of their abilities.

People told us they felt safe and staff were kind and caring. However, our observations and findings showed that people were at risk of receiving unsafe care.

People were not protected from the spread of infection. The provider had failed to ensure government guidelines for working safely in care homes during the COVID- 19 pandemic were implemented and adhered to.

Risks to people's health and welfare had not always been assessed and detailed guidance was not always available for staff to refer to. Monitoring records were not always fully completed.

Pressure relieving equipment in place such as, pressure relieving mattresses, were not always set correctly which put people at risk of skin damage.

Medicines were not managed or stored safely. People had not always received their medicines when required or received them correctly. Where people were prescribed medicines given 'as required', guidance for staff was not always in place. This increased the risk people's medicines may not be given safely or effectively.

The provider did not demonstrate there were always safe staffing levels, this meant people were not always receiving care and support when they needed it.

The provider had failed to ensure staff had the required competencies or knowledge to meet people's needs safely. Staff had not received training to meet the specialist needs of people they supported.

Effective processes were not in place to monitor staff performance, provide feedback or listen to staff concerns. Staff had not had regular supervision, appraisal or team meetings.

People did not always have access to specialist diets in line with their support needs. Concerns were raised with us about the quality, variety and consistency of modified texture diets. The mealtime experience within the service was inconsistent.

Staff did not fully understand their roles and responsibilities under the Mental Capacity Act 2005. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People did not live in a service that was properly maintained. We saw some furniture was worn and stained, paint had chipped or worn off doors and skirting revealing bare wood and the carpeting in communal areas looked dirty and heavily stained. People told us their furniture, such as chairs, were broken and they were unable to use them.

People told us they felt safe and staff were kind and caring. At the time of the inspection it was not clear what systems and processes were in place to keep people safe from abuse. However, staff had received safeguarding training and knew what they would do if they thought someone was being abused. We made a recommendation to the provider about reviewing their processes in place to ensure they were robust.

Whilst recruitment checks were in place, full employment histories were not always recorded or corroborated. We made a recommendation about this.

Following the inspection, the provider took immediate action to make improvements, and developed an action plan based on our feedback and their own observations. Prior to the inspection the providers had taken action to strengthen the leadership at the service and had employed a strong management team to support the service.

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

Why we inspected
The inspection was prompted due to concerns received about the provision of basic services; such as hot water, the quality of care, staffing, infection prevention and control, medicines management and governance and leadership at the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well led only.

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

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, staffing and staff training, person-centred care, consent to care, the environment people live in and governance systems and processes at this inspection.

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

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

# Colebrook Manor

**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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was conducted by four inspectors, a medicines inspector, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Colebrook Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This meant the provider was legally responsible for how the service was run and for the quality and safety of the care provided.

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 this included information we had received from whistle-blowers and the local authority safeguarding team in relation to concerns raised. We sought feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with seven people who used the service and five relatives about their experience of the care provided. We spoke with 24 members of staff including the provider, operations director, interim manager, administrators, registered nurses, care workers, the chef, domestic staff and maintenance staff. We used the principles of the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 14 people's care records and 10 medication records. We looked at three 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with the multi-professional team supporting the service.

Inadequate

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Prior to the inspection we had been told about concerns related to the provision of hot water. In addition, we had been told there were not enough staff to meet people's needs, the quality of care was a concern, and medicines and infection prevention and control were unsafe. We looked at this as part of our inspection and found improvements were required.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- Prior to the inspection we received concerns that all areas of the service did not have hot water. We looked at this as part of the inspection and found the service had issues with their hot water system since the beginning of August 2021. We asked the provider about this and they gave us assurance this was being addressed. However, during the first day of the inspection, we found staff were carrying hot water around the building in bowls and kettles. This was unsafe and placed staff and residents at risk from burns and scalds. We brought this to the attention of the interim manager who took immediate action.
- Risks to people's health and welfare had not always been assessed and detailed guidance was not always available for staff to refer to. This put people at risk as staff did not have all the information needed to keep people safe.
- People with diabetes were not always being supported safely. For example, one person self-administered their own insulin. There was no risk assessment to show this was safe and staff had no record of how much insulin was being administered or who was responsible for monitoring blood sugars. Their care records did not contain guidance for staff about how to identify if they were becoming unwell because their blood sugar levels were too high or too low or what action staff should take to keep the person safe. There was no information about regular diabetic checks, such as specialist foot and eye care services.
- One person was receiving oxygen therapy delivered through a specialist machine. No care plan or risk assessment was in place to show how this was safely managed. Senior staff were unable to tell us how to use the machine and told us they had not received any training.
- People's skin care was not always being managed safely and/or in line with their care plans. For example, one person had a pressure sore on their hip. Their skin care plan advised staff they required 'turning regularly' as they were unable to move themselves. There was no guidance about how often they should be repositioned. Monitoring records for this person showed they were not being supported to change their position for long periods of time, particularly at night. The provider could not be assured that this person was being kept safe.
- People who had been assessed as at risk of choking were not always being supported safely and/or in line with their care plans. For example, one person who had been assessed as needing staff to help them eat, was left alone with their food. This put the person at risk of choking.
- Pressure relieving equipment was in place such as, pressure mattresses and cushions. However, we found pressure mattresses were not always set at the correct pressure for the person's weight, which meant they

could be at risk of unnecessary skin damage. There was no guidance in care plans or risk assessments to instruct staff on what pressure the mattress should be set at. Daily mattress checks had not been completed since April 2021.

● The provider had not always taken the necessary steps to prevent and control infection. Staff were observed either not wearing a mask, wearing their mask below their chins, or wore loose fitting masks which slipped below their noses. Whilst the interim manager addressed this issue during a staff meeting held during our inspection, we continued to see staff wearing their masks incorrectly throughout the inspection.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Staff told us they were not always supplied with appropriate cleaning products and would also regularly run out of cleaning products. For example, staff told us they were using bathroom cleaner to wipe tables and waterproof mattresses, when it should be an anti-bacterial spray.

● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. We found some used personal protective equipment (PPE) not disposed of correctly.

● We were not assured that the provider was preventing visitors from catching and spreading infections. Not all professionals visiting the service had their temperature taken as stated in the service policy.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. A failure to ensure care and treatment is provided in a safe way is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Whilst risk assessments and care plans were not always in place for people living in the residential unit, care plans in the nursing unit were in place and were sufficiently detailed.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

● We were assured that the provider was admitting people safely to the service. The providers admissions policy was in line with current national guidance. This meant staff had clear guidance on how to admit people safely during the pandemic.

● We were assured that the provider was accessing testing for people using the service and staff.

Using medicines safely

● Improvements were needed to the way people's medicines were managed.

● Records showed that people did not always receive their medicines correctly in the way prescribed for them. For example, one person was prescribed a medicine in a reducing dose. Records showed that the doctor's instructions had not been followed. Another person was prescribed a course of medicines for seven days. However, records showed this had been signed as administered for nine days. Two people had one or more gaps in their medicines records where doses had not been signed for, or a reason recorded if the dose had not been given. This meant the provider could not be assured that people were receiving their medicines as prescribed for them.

● When medicines doses were changed, this was not always recorded in a clear and safe way on peoples' medicines charts. This meant there was an increased risk that these medicines would not be administered safely.

● When medicines patches were applied, the site of application was not always recorded by staff. When sites were recorded, they were not always rotated in line with the manufacturer's recommendations.

● Records showed that medicines prescribed to be applied to people's skin were not given as prescribed. For example, one person was prescribed an anti-inflammatory gel three to four times a day for pain relief. Their Topical Medicines Application Record (TMAR) showed that they had not received this medicine as

prescribed for them.
● Individual protocols designed to support people receiving 'when required', medicines were not always in place. One person was prescribed a sedative medicine. However, their medicine records did not effectively record doses and frequency's. This put the person at risk of under and over prescribing.
● People's records contained a medicines section in care plans, but the details recorded in these were not always up to date. For example, one person was recorded as self-administering their medicines, but staff were administering them. Another person was recorded as having all their medicines in liquid form to be administered by a feeding tube, but this was not the case as some were supplied in tablet form. There was no recorded advice from the GP or pharmacist confirming that doses were safe to crush or suitable to be given in this way.
● Prescribed thickening agents were not always stored safely which put people at risk. For example, thickening agents were left in an unlocked cupboard within a communal area of the home where people walked with purpose. We also observed that staff used other peoples prescribed thickeners for people. We raised this with the interim manager who assured us this would be addressed. When we returned eight days later, action had not been taken.
● Temperature recording systems for medicines were inconsistent. The room temperature on the nursing unit was recorded as higher than that recommended by manufacturers on several occasions, meaning that we could not be assured that these medicines were safe and effective. Refrigerator temperature ranges were recorded which provided assurance that these were stored appropriately. There were suitable storage arrangements for medicines requiring extra security. We were told that weekly checks took place, and these were signed as having been done on the nursing unit but not recorded on the residential floor.
● Staff received some training in safe medicines handling. However, senior care staff told us that they felt they had not had enough training or time to become confident in safely administering medicines. Nurses were unsure where responsibilities lay with regard to medicines being administered by senior care staff in the residential unit.

A failure to ensure medicines are managed in a safe way is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
● People were not always supported by enough, suitably skilled staff. People and relatives told us staffing levels were not sufficient or consistent. A relative told us, "They are very short of staff, they are struggling. They have to use agency staff and there is no continuity of care." Another relative said, "Staff do their best, but they are always short staffed. They always take a long time to come to her when she presses the buzzer."
● Staff told us staffing levels were not sufficient to meet people's needs. During the inspection we saw staff were generally rushed and focused on the task at hand rather than supporting people in a person-centred way. For example, one person assessed as requiring assistance with eating and drinking, was left unsupported for 18 minutes.
● Staff told us five staff were available to support 11 people during mealtimes in the nursing unit. One staff member told us, "It's a lovely home we just need more staff. You have 25 clients upstairs and five staff, you haven't got time to finish supporting one person before the other and you have the buzzers going on. You're rushing them, it's dangerous and it's not fair at all." Another staff member told us, "We keep saying we need more staff and we're told to get on with it."
● The provider used a dependency tool to assess how many staff were needed to care for people. The interim manager told us the required staffing levels were five care staff and a registered nurse on duty for the day shift in the nursing unit and three care staff and a senior carer in the residential unit. On review of the rotas given to us during the inspection, we found ten shifts between 16 August 2021 to 12th September 2021 did not have the minimum amount of staff required by the provider, allocated to work on that shift.

Sufficient numbers of staff were not always provided to provide safe and consistent care to people. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were in place to promote safe recruitment practices. Recruitment checks such as police checks and reference checks on staff members previous employment, had been completed. However, full employment histories, with any gaps in employment explored and accounted for, had not always been obtained in line with requirements and the providers policy.

We recommended the service works to best practice and own recruitment procedure to ensure staff are suitably and safely recruited.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe and staff were kind and caring. It was clear that staff cared deeply for the people they supported and wanted to do the very best for them. Comments from people included, "I feel very safe here", "Staff are very good and yes, I feel safe here" and "Feel safe in here and with staff as I can call them anytime."
● During the inspection we discussed with the interim manager the arrangements in place to capture record and analyse safeguarding concerns. At the time of the inspection the interim manager had only been in the service for two day and was unaware of the policies and procedures in place. However, we found staff had received safeguarding training and knew what they would do if they thought someone was being abused to keep people safe. One staff member told us, "I would go to the nurse in charge and then the manager and safeguarding. I haven't witnessed anything like that."

We recommended the provider reviews their safeguarding systems and processes to ensure they are operated effectively to investigate and act on, any allegation or evidence of abuse.

Learning lessons when things go wrong
● Although accidents and incidents were recorded, other than if the accident or incident was a fall, there was no system in place to analyse accidents and incidents so that lessons could be learned, and improvements made to people's care and support.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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

- The provider had failed to ensure staff followed current legislation, standards and best practice guidance to achieve effective outcomes. For example, the provider had not ensured staff were adhering to COVID-19 requirements to wear PPE correctly.
- People's needs were assessed prior to admission to the service and care plans were developed based on the information obtained during the assessment process. However, we found care plans were not consistent in detail throughout the service and did not always reflect best practice. For example, there were detailed care plans for people living with diabetes in the nursing unit but not in the residential unit.
- People's needs were not always regularly reviewed. For example, one person's monthly care plan reviews had not taken place between February 2021 and July 2021.

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

- Specialist diets were not always being provided. For example, people who were diabetic were not offered a diabetic diet and vegetarian options were not always available. One staff member told us, "There's no vegetarian option and we have a vegetarian resident." They went on to tell us that the person was living with dementia and for a while they were given meat which was not their choice.
- Some people were receiving a modified textured diet. Concerns were raised with us about the quality and variety of these meals. We brought this to the attention of the cook and the interim manager and action was taken during the inspection to make these meals more attractive and varied.
- Staff told us that food quality and portion sizes were typically small and they were concerned people were not having enough to eat. One staff member told us, "Everything's on a budget, the food has gone downhill, it used to be great."
- The dining experience of people in the upstairs nursing unit of the service was a stark contrast from those people living on the residential unit. For example, we observed the lunch time experience on the nursing unit and found the tables had not been laid with tablecloths, cutlery or condiments. The tables were stained from previous mealtimes.
- One person required the use of a protective cover to keep their clothes clean, this was placed over the persons head with no consent or interaction.

The provider failed to ensure people's care was delivered in a person-centred way. This was a breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In contrast, we observed that during the dining experience downstairs people were sat together at tables which had been laid and were enjoying a communal event.
● People mostly told us they enjoyed the food and were offered choices. Comments included, "Meals are good", "Enjoy the food exceptionally good!" and "Food, pretty good and plenty of it and a good choice." Another person told us, "If I ask for drink or food, they will always bring it. Today I don't like what's for lunch, so they are doing me a different meal." However, some people felt the food was "Average" and "Doesn't cater for me." A relative felt that the food was "Up and down."
● People's nutritional needs were identified in their care plans. People at risk of not eating and drinking enough to maintain their health, had their intake monitored and weight regularly checked which reduced the risk of malnutrition and dehydration.

Staff support: induction, training, skills and experience
● Although staff received online training in subjects the provider deemed necessary to meet the needs of people using the service, staff felt the training was not adequate.
● Staff told us they had not received any face to face training since the start of the pandemic. One staff member told us, "Training is a real issue. No moving and handling, a lot of the new carers haven't had manual handling training, we've done theory online but no practical update for a while."
● Training in key subjects relevant to the needs of the people living in the service had not been provided. For example, staff had not received training to support people living with dementia.
● Staff told us they had not received training to support people with their complex health needs such as, people living with diabetes, epilepsy or people who needed to use an oxygen machine.
● Care staff had not undertaken any training about skin care and prevention of pressure ulcers, although several people were assessed as being at high risk with regard to their skin integrity.
● Senior staff responsible for overseeing care in the residential unit told us they had not received any training on how to write person-centred care plans and had not received any support from the provider to develop skills in this area.
● The provider had not ensured there were effective processes in place to monitor staff performance, provide feedback or listen to staff concerns. Staff told us they had not had regular supervision, appraisal or team meetings and did not feel supported by the provider.

Staff did not always receive the appropriate training and support in order to meet people's individual needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being

met.

● Staff did not fully understand their roles and responsibilities under the Mental Capacity Act 2005. This meant that people who lacked capacity or had fluctuating capacity, did not always have decisions made in line with current legislation.
● Mental capacity assessments had not been carried out for people in relation to their capacity to make decisions about their care and whether they were able to give consent. People who were considered by staff to not have capacity to make decisions, had general consent forms signed by staff on their behalf. There was no evidence that staff had followed the best interests process which involved the person, their relatives and/or appropriate healthcare professionals.

The failure to assess people's capacity and record best interest decisions risked compromising people's rights. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed staff giving people choices and asking for their consent before giving care.

Adapting service, design, decoration to meet people's needs
● Colebrook Manor was a large building set over two floors. Following a tour of the home we noted the service did not have a homely feel and areas of the service needed redecoration.
● We saw some furniture was worn and stained, paint had chipped or worn off doors and skirting revealing bare wood, which would be hard to clean, and wallpaper was peeling off in some areas. Generally, the carpeting in communal areas looked dirty and heavily stained.
● People told us their furniture, such as chairs, were broken and they were unable to use them. One person said, "I spend most of the time in bed, because there is no comfortable chair, they are all broken." A relative told us they had complained to staff that the side lights in their relatives' room were not working but nothing had been done to fix them.
● We also noted the garden was overgrown and neglected which meant people could not use the garden for leisure.

This failure to ensure the premises was properly maintained was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although the service required significant cosmetic work to improve the environment for people, there was an ongoing maintenance plan in place.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● At the time of the inspection other agencies were working with the provider due to the concerns raised and the ongoing monitoring of the quality of care provided to people.
● Best practice tools were used by staff to assess and monitor people's needs. For example, those at risk of poor food and fluid intake, pressure damage and choking.
● Staff sought support from health care services to ensure effective and timely assessment and care. For example, staff were concerned about one person's swallowing whilst supporting them to eat and sought advice from a nurse who said they would re refer to the speech and language therapy team for assessment.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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.

Prior to our inspection CQC had received concerns about the management, leadership and culture of the service. We looked at this as part of our inspection and found improvements were required.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service had not had a registered manager in post since September 2019. This meant the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run was the responsibility of the registered provider.
- The provider had employed a series of managers to support the service since 2019. However, we found the provider had failed to have sufficient oversight of the service during this time to ensure people received safe and consistently well-managed care and support. Systems operated by the provider to assure themselves of the quality of care provided had failed to identify concerns and shortfalls we found during this inspection.
- Quality checking processes and audits were either not in place, not completed or were ineffective. For example, recent audits of medicines had taken place but did not identify all of the issues that we found.
- Some audits had not been completed for a number of months, such as air-wave mattress checks.
- There was no oversight of monitoring charts to ensure people received appropriate care. This meant people were at risk of receiving poor care because the risks to their safety and well-being were not being managed effectively to protect them from harm.
- The provider's quality and monitoring systems had failed to ensure that legislation was complied with. For example, mental capacity assessments and best interests decisions were not completed and staff lacked understanding of the requirements of the Mental Capacity Act 2005.
- The provider failed to ensure infection control was well managed in the service to ensure people were not at risk from cross infection.
- The provider's quality and monitoring systems had failed to ensure all people who lived at the service had an up to date and complete risk assessment and care plan to fully meet their needs.
- The provider had not identified staff were not suitably trained or employed in sufficient numbers to keep people safe.
- The provider had failed to ensure people lived in a well maintained pleasant home.
- Roles, responsibilities and accountability arrangements were not clear. Staff had seen a number of managers start and leave the service and there was no continuity of management. One said, "You have no support, you have no back up, you only have each other." Another said, "It's been awful, you don't know who to turn to."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The lack of effective leadership did not promote and ensure a positive and person-centred culture in the home.

● We observed staff were trying to provide care to the best of their ability and spoke passionately about their work and the people they were supporting. However, staff were not receiving the support and guidance from the provider to enable them to do this effectively. One staff member told us, "We've had seven managers, it's just not been brilliant, you get one person and you get used to them and then they leave." Another staff member told us, "The staff have been holding it all together with no support from managers or directors."

● Staff told us they did not feel listened to, valued or supported. Staff reported morale as extremely low. One staff member told us, "Morale is very low, it's not a good place to work or live." Another staff member said, "There's no thanks for our hard work. We worked all through COVID, and there was just no thanks. They [the providers] are not thinking about staff and residents."

● Staff did not have regular supervisions or staff meetings. This meant there was no forum for staff to discuss any concerns before they escalated. Staff did not have the opportunity to address any issues relating to their well-being, training or morale. One staff member told us, "We don't have regular meetings, the one we had last week was the first in a few months and the one we had a few months ago was for the new manager to introduce themselves."

● Previous systems in place to gain people's views or to hear their feedback about the service, had not been maintained. Feedback from people using the service, such as questionnaires, had not been obtained since 2019. However, administrators told us they were in the process of sending these out. People and staff told us there were no meetings for people or relatives. A relative told us, "Nobody rings up and asks for my views."

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

● Although the provider was aware of their responsibilities under the duty of candour to be open and honest when things went wrong, feedback from relatives about the lack of information they had received about issues with hot water in the service, did not assure us the provider was doing everything possible to be open and honest with people using the service.

Due to the lack of governance and oversight of the service, people were placed at risk of harm. The service had not ensured there was a positive and open culture that achieved good outcomes for people and the provider was not always open and transparent with service users and other relevant persons. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed what we found with the providers who acknowledged that some concerns had been a direct result of the unstable and ineffective leadership and oversight of the service. The providers had already taken action to strengthen the management and leadership in the service and had employed a strong management team, to support staff. We found the providers were responsive to our feedback and demonstrated a good understanding of the improvements needed.

● Following the inspection, the provider took immediate action to make improvements, and developed an action plan based on our feedback and their own observations. This was shared with CQC and commissioners.

● Although we received mainly negative feedback from staff about the support they had received from the provider, some staff felt that communication and support had recently improved. One staff member told us, "Since we've spoken to [operations director's name] about how we feel they are starting to listen. I've been

speaking to [operations director's name] a lot lately and she's said to call me if I need anything."

Working in partnership with others

● At the time of our inspection the local authority and other agencies were working alongside the provider following the number of concerns raised regarding the standard of the service provided.

● Staff had developed links and working relationships with a variety of professionals within the local community such as GP's and the local district nurses.

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<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider had failed to ensure people's care was delivered in a person-centred way. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider failed to ensure systems were in place to assess people's capacity and record best interest decisions. Staff did not fully understand their roles and responsibilities under Mental Capacity Act 2005. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The provider had failed to ensure the premises was properly maintained and was a nice environment for people to live in. |