Care Quality assessment for Gabriel Court Limited Care Homes

Overview

Overall Rating: Inadequate

The service is performing badly and we've taken action against the person or organisation that runs it.

Summary

Safe	Inadequate
Well-led	Inadequate

Overall Service Commentary

Date of assessment 15 May 2024 to 3 July 2024. Gabriel court is a residential care home providing accommodation and personal care to up to 44 people. At the time of our assessment there were 34 people using the service. As part of our assessment activity, we undertook on-site visits on 15,17, 20 and 22 May 2024. This assessment was prompted by information we held about this service and to follow up on previous enforcement action .

We assessed a total of 15 quality statements. At our last inspection the service was rated requires improvement and conditions were imposed on the providers registration. During this assessment, we found several concerns with the quality and safety of people's care. We identified three breaches of the legal regulations in relation to safe care and treatment, staffing and governance. The overall rating of this service has changed to inadequate. This service is being placed in special measures. The purpose of special measures is to ensure that services providing inadequate care make significant improvements. Special measures provide a framework within which we user our enforcement powers in response to inadequate care and provide a timeframe within which providers must improve the quality of the care they provide.'

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Overall People's Experience

People told us they felt safe, however, we found that practices in the service meant that people were not always protected from the risk of harm. There was not always enough staff to keep people safe and this had impacted on some people's care. People were not always protected from unsafe environments and we found people were at risk for example of being exposed to chemicals and increased risks in an emergency evacuation for a fire. The service had failed to embed and sustain improvement, there had been a high turnover and staff and management, which had impacted on people's care and their needs were not always met. The home had deteriorated to and overall rating of inadequate. People told us their rooms were clean, there was still some work to do to protect people from the risk of infection. People received their medicines as prescribed.

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Safe

Rating: Inadequate

Percentage Score: 34.00 %

► How do we score this?

Summary

This service is not safe

Commentary

At the last inspection the provider was in breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this assessment the provider remains in breach of regulation 12. Conditions imposed on the provider's registration from a previous inspection remain as they were found to be not fully met. At this assessment the provider is in breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. We will request an action plan for how the provider will improve. People were not safe we found concerns with people’s risk assessments and care plans not containing current and accurate information to reflect their needs, staff did not always have the information needed to keep people safe. People were at risk of injury from poor manual handling, poor environment and insufficient staffing. Accidents and incidents were not accurately recorded and analysed to prevent future incidents. Further improvements were required in infection control to minimize risks to people. Medicines were managed safely and people received their medicines as prescribed.

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Safe

Learning culture

Overall Score

1 **2** **3** **4**

▶ How do we score this?

Summary

Inadequate - This service does not maximise the effectiveness of people’s care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

We observed staff carrying out poor moving and handling, we informed the manager. People remained at risk of injury from poor moving and handling as the manager failed to take immediate action to ensure all staff complied with safe moving and handling. CQC raised a safeguarding alert. Following our feedback, the manager carried out spot checks of staff moving and handling over the next few days and spoke with staff about safe moving and handling. People experienced falls which were not always accurately recorded or investigated. People remained at risk of falls as their risk assessments and plans had not always been updated to reflect their falls, or action taken to prevent further falls. One person had fallen at night; staff reported they had been confused. They also fell again in the early hours of the next morning in a communal area, they were in the area unsupervised. One person told us they had experienced a fall, they said “staff were there to help”.

Feedback from staff and leaders

Staff we spoke with were able to demonstrate how they should report accidents and incidents. However, we were not assured and records did not support that accurate recording always took place. One staff member told us they were not reassured that all staff recorded accidents when they occurred, they said they were witness to an incident that was not reported. Another staff member told us “There was meant to be an assessment tool for falls but I don’t think we have been able to use this yet – something for future.” A staff member told us that extra checks had been implemented on sensor mats when it was found that some people were unplugging them in their rooms, sensor mats are a safety device used to alert staff when someone gets up from their bed or chair and may need staff assistance.

Processes

The process for recording incidents and accidents was not robust enough to contain all the relevant information needed to learn from these. The analysis of accidents and incidents did not capture all the events, nor have actions to reduce risk or prevent future incidents. For example, 3 incidents that had occurred in the last 3 months were not included in the analysis and no action had been taken to mitigate the risks of people falling at night. There was no reliable system to capture people’s experiences with poor moving and handling, incidents and accidents for analysis for themes and trends to be used for further development and improvement of the service.

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Safe

Safe systems, pathways and transitions

Overall Score

1 2 3 4

▶ **How do we score this?**

Summary

Inadequate - This service does not maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

People who had been admitted to the home had not had all of their risks assessed or care plans created to mitigate risks. New people to the service were at risk of not having their needs met. For example, one person had been assessed as at high risk of falls and pressure ulcers, but there were no care plans to inform staff how to mitigate these known risks at the time of our site visit. Another person readmitted to Gabriel Court had not had their nutrition reviewed from admission for 3 months, they had lost weight in that time. Care plans for diabetes and oral care were not reviewed regularly. Another person admitted did not have care plans for their medical conditions or catheter. Staff did not know how to look after them, they did not receive care that met their needs and they were admitted to hospital. People told us they were supported to attend healthcare appointments when needed. One person told us, "Two of them come with me". One person told us they were supported with attending dentist appointments.

Feedback from staff and leaders

Senior staff managed transitions into hospital and referrals to other health care professionals. Care and medication records were sent with people for

emergency admissions along with a 3 day supply of medicines and some clothing. A staff member told us, when away from home people were removed from the electronic system, “This is a good system for fire safety but, not everyone is taken off the system”. The staff member went on to tell us that only care managers can complete this task so there is sometimes a delay. This meant there was a risk staff would not know someone was away from the service during an emergency evacuation. People’s risk assessments and care plans had not always been reviewed regularly or as people’s needs changed. The manager told us they would get round to reviewing all the risk assessments and care plans by the end of June 2024.

Feedback from Partners

One partner agency told us “Since [the new management team] have been in the home, care plans have been much more detailed, and person centred, however they are not always updated. “Overall, I believe that Gabriel Court Management has started to make progress, but there is still room for improvement.” Another partner agency told us that although the provider had been cooperative and proactive in improvement, progress had been hindered and regressed at times due to the lack of a consistent registered manager. The lack of a stable management team was described as a very unsettling time for Individuals who lived at the service, and the staff group. A new manager had been appointed at the time of our site visit and has remained in post since.

Processes

There was no effective system to ensure all people being admitted to the home had their risks assessed, care plans created to mitigate risks or instructions for staff implemented within the electronic care planning system. This meant people were not receiving care that met all of their needs, placing them at risk of harm from unmet needs because staff did not have all the information they needed to provide safe care. The provider was made aware of these shortfalls and added their actions to improve the processes in their action plan.

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Safe

Safeguarding

Overall Score

1 **2** **3** **4**

▶ How do we score this?

Summary

Inadequate - This service does not maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

People who required assistance to move were not always being moved safely. This placed people at risk of bruising or other injuries. A relative told us they felt their relative was safe but described the hoist as, “Horrible, but can't be helped.” The person had experienced bruising and the reason was explained by the staff team as “It was new staff, not experienced enough.” People told us that they found staff to be kind and caring and felt safe with them. One person told us that they felt safe with staff and in the building which was secured, they said, “Noone can just get in here.” People told us that if they didn't feel safe they would speak up to either a family member or the home manager.

Feedback from staff and leaders

Staff told us they had raised concerns about unsafe moving and handling and unexplained bruising with the manager but had not seen any actions taken. Staff told us they did not feel they were listened to. The manager showed us the incident forms completed by staff; the information was incomplete and did not accurately reflect all the details of the incident or accident. The manager told us they were planning on additional supervision and training in how to report an incident. Some staff were able to demonstrate they understood the signs of abuse. One staff member told us they always reported signs of abuse. Another staff member told us they had raised a concern with the management team but they did not believe this had been actioned. One staff member told us general care was lacking and resulted in one person being dressed in a skirt that was too small which then had to be cut off. Some staff members were unsure around the signs of abuse or how to report them independently of the home.

Observation

We observed staff using unsafe moving and handling methods, placing people at potential risk of harm. We brought this to the attention of the manager who spoke with staff about their moving and handling practice. The manager failed to raise a safeguarding alert. CQC raised a safeguarding alert.

Processes

Where safeguarding alerts had been raised with the local authority, these were followed up appropriately. However, where staff told us there had been unsafe moving and handling and unexplained bruising, these had not been recorded or any evidence this had been followed up. Safeguarding and whistleblowing policies and procedures were in place. However, they were not always followed in practice and did not contain clear concise guidance for staff or contact details on how to contact other organisations.

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Safe

Involving people to manage risks

Overall Score

1 2 3 4

► How do we score this?

Summary

Inadequate - This service does not maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

People were not receiving care that met their needs as staff did not have all the information they needed. For example, for preventing falls, skin integrity, bed rails, nutritional and mobility needs. One person told us staff would take them into the garden if they asked but this wasn't offered by staff regularly. The person hadn't been involved in developing their care plan, they described it as "more or less drawn up for me" but they told us they could ask for more or less help when they chose. Some people told us they had been involved in planning their care and in the updates One person told us they had raised with the home that a piece of equipment was hindering their independence and this was rectified by staff.

Feedback from staff and leaders

The new manager planned to start reviewing risk assessments and care plans in June 2024. The manager said, "The existing care plans are not detailed enough." One staff member said that records contained little information or are blank so care cannot be personalised. A staff member told us there had been issues with people disconnecting their sensor mats as they did not like the noise. Another staff member told us that one person regularly moved their mat as they didn't feel they needed it, they told us that the person needed regular explanation as to why the mat was their but not all staff took the time to do this. The staff member told us this worried them as the person was at high risk of falls. A staff member told us that when everything was in place then people will be safe. They told us that they advised the management team and shared with other staff members if they identified a risk to people. Another staff member did

not have knowledge or understanding of risk assessments in the service, they said, “I don’t think we have risk assessments in this care home, I have enough information for residents, I just look on the device for that.”

Observation

Not all the risk assessments and care plans have been reviewed since the new manager arrived in February 2024. People were not always receiving care that met their needs, staff did not have all the information they needed to know how to mitigate risks and meet people’s needs. Where people had falls or incidents, the manager sometimes recorded 'Care plans updated.' There was no evidence of people being involved in their risk assessments or care plans. We found delays in risk assessing and care planning for people on admission. This meant people an increased risk of harm as staff did not have the information needed to keep them safe.

Processes

The provider and management team had failed to work with people to understand and manage risks by failing to think holistically so that care met their needs in a way that is safe and supportive.

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Safe

Safe environments

Overall Score

1 2 3 4

▶ How do we score this?

Summary

Inadequate - This service does not maximise the effectiveness of people’s care and treatment by assessing and reviewing their health, care, wellbeing and

communication needs with them.

People's Experience

People were not always protected from unsafe environments. People who were mobile could access the kitchens in Bluebell and Foxglove units. The kitchen door in Foxglove was left open when unattended, providing access to the hot urn, oven and COSHH. People could access the car park and stairs to Bluebell, via the main kitchen, exposing them at risk of harm from hot appliances. One person had not been assessed for the use of bed rails. Staff recorded they used their bed rails at night, however, the bed rails were broken and posed a risk of entrapment. One person told us that equipment was not always well maintained they described how a piece of equipment that they need was regularly out of order as staff failed to ensure it was charged and ready for use. This meant their mobility was regularly restricted. One person told us the home was drafty and very cold in the winter, they said the curtains were very thin and didn't help with draughts. They also described the garden as unkempt. However, another person told us the home was clean and well maintained. People told us there were regular fire alarm tests but could not recall their being a drill.

Feedback from staff and leaders

The manager carried out daily safety checks, however, these had failed to identify risks such as people having access to kitchens, COSHH and stairs. Following our feedback the manager put some systems in place, but we observed staff were not adhering to the new systems, such as keeping the kitchen door closed when not in use. A staff member told us that they had noticed on occasion cleaning products had been left in the communal lounge. Staff told us they knew how to evacuate. One staff member told us "We have a fire drill every Friday and they will test systems, we know where the signs are, things are being fixed and updated making sure residents are safe." We were not reassured that all of the night staff team were well prepared for an emergency evacuation. One staff member said that it would be difficult with the number of staff available, they said, "We would have to just think about it at the time." Fire evacuation records evidenced that evacuations recorded in the last year have shown 'failure' or 'unsuccessful' due to staff not knowing what to do, this had not been followed up to ensure that staff were capable and competent.

Observation

The fire doors had been replaced to most bedrooms; these were unlabelled; there was no indication of who occupied each room which could cause difficulties in an emergency such as a fire. There was no signage to denote the use of oxygen. Staff did not have access to the cellar area where the emergency gas valve was situated. The doors to the cellar had been replaced, but staff did not know where the new keys had been stored. There was furniture and equipment stored in people's rooms, which did not belong to or were not used by them. People's beds that had bed rails had not been checked for safety. Some bed rails were broken leaving large gaps which could cause entrapment. People's bedrooms and bathrooms contained exposed hot water pipes. Staff charged hoist batteries in people's bedrooms. Following our feedback the manager arranged for the hoist recharging stations to be moved to other areas. However, in Foxglove, the hoist chargers were attached to an extension lead, in a storage area in the communal lounge; this is against safety advice which states these should be stored away from flammable sources. One person had a portable heater in their room, although this was not plugged in, there was a risk this person could be burned if they had touched this when it was on. The senior's office in Foxglove was not always locked, and on one occasion the door was left open. The room contained the storage of medicines to be returned, equipment and people's personal information. People were at risk of accessing medicines and private information. Cleaning staff stored their cleaning trollies containing COSHH in people's bedrooms. People were at risk of harm as they had access to COSHH items. The only access on the ground floor between the two units of Bluebell and Foxglove is through the main kitchen, down some brick steps and across the car park. Visitors to the home, including health professionals and staff use the kitchen as a throughfare. This had not been risk assessed.

Processes

The manager told us they carried out safety walk arounds each day to check the environment. These had failed to identify that people's doors had not been labelled, the lack of oxygen in use signage, storage of furniture and equipment, safety of bed rails, access to medicines, access to the cellar, access to kitchens and hot appliances. The manager failed to identify the emergency PEEPS were out of date, as these included people who had left the home and did not include all the people in the home. This posed a risk in the event of an emergency that emergency services staff would not know who was in the home, or their evacuation needs. Check sheets were in place to check fire safety equipment however we noted some gaps in weekly fire alarm testing.

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Safe

Safe and effective staffing

Overall Score

1 **2** **3** **4**

▶ How do we score this?

Summary

Inadequate - This service does not maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

People who were known to be at risk of falls were not always supervised in communal areas. Staff did not understand their role in keeping people safe from falls. People who required help to eat and drink did not always receive the help they needed from staff in a timely way. People did not always receive their food and drink to meet their needs. Staff did not always understand when they needed to thicken fluids; people were at risk of aspiration as staff did not always thicken soups or cream when required. Staff did not have all the knowledge and skills to know what type of food and drink was safe for each person. People who experienced falls or other incidents relied on staff to record these accurately and take appropriate action. Staff failed to record all the information about accidents and incidents. People gave a mixed response on if there were enough staff. One person told us they thought there was enough staff as they didn't have to wait more than a few minutes for response to a call bell, with another person commenting "there are quite a few (staff) in here today . Another person said "It varies, anything from 5 to 15 minutes, its better in the day". People told us they saw the same regular teams of staff. One person told us that there was not enough staff and told us how this impacted on them, they said "Well, say one of us wants the toilet, we can be bursting, that's how it affects us".

Feedback from staff and leaders

The manager told us they had identified staff did not complete accurate or detailed records of accidents and incidents and care records. They did not have a plan on how they were to manage this in the short term, however, they told us they understood staff would need additional training and supervision to become competent. The manager told us they understood the need for people to be protected from falls, hot appliances and cleaning products. However, during the inspection staff continued to place people at risk as the manager had not successfully imposed systems that staff followed. Staff told us they had brought concerns about poor moving and handling to the manager in the past, however, there were no records of these concerns, and the manager had not taken any action. Staff mostly didn't think there were enough of them to keep people safe. One staff member told us, "Definitely not enough staff to keep people safe, I am worried there will be a bad accident." Another staff member said, "There are not enough staff to deal with all residents". A staff member told us that there are sometimes more than enough staff at night that could be better deployed across the service, however, another staff member disagreed and described the night staff numbers as dangerous. Staff told us a lack of staff on bluebell unit meant that people's needs could not always be met. One staff member said, "Not enough staff for the residents that are in there – they have a lot of needs and we are short staffed. This is a risk for everybody." Another staff member described staffing levels as not safe. Staff training was mostly on line but also 1:1 sessions, staff felt this was adequate but one commented there was not many shadow shifts for new starters. One staff member felt more NVQ training would benefit and incentivise staff.

Observation

People who were at risk of falls were left unsupervised in communal areas, placing them at risk of harm from falls. Staff who walked through the communal areas did not identify people who were at risk of falls were being left unsupervised. We observed poor moving and handling practices. Staff did not recognise poor practice in their own actions or raise concerns about poor moving and handling practice being carried out by other staff. Staff left kitchen doors open, and cleaning products in easy reach of people. Staff did not recognise the risks of people accessing hot appliances or cleaning products.

Processes

The provider failed to meet the conditions of their registration, requiring them to ensure people were suitably supervised in communal areas.The provider failed to have systems to ensure there were enough staff deployed to meet this condition and therefore failed to prevent the risk of falls for people. Not all staff had received the supervision required to ensure they carried out safe moving and handling. Staff had not always received competency checks or adequate supervision to ensure all people were protected from the risks of hot appliances and substances that could be harmful to their health. Staff had not received the training or had their competencies checked to ensure they completed accurate records of care and accidents and incidents.

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Safe

Infection prevention and control

Overall Score

1 2 3 4

▶ How do we score this?

Summary

Requires Improvement – This service generally maximises the effectiveness of people’s care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

People told us their rooms were clean and they felt the home was clean and tidy. One person said, “They [satff] check it every day, if it needs doing, they do it” and “when they want to give it a good clean, they ask me to go to the lounge”. People had a mixed experience of the laundry service in the home with some people having no or “no major” issues. One person told us laundry was often mixed up. People said they had vaccinations when needed including flu and COVID 19 Vaccinations.

Feedback from staff and leaders

Following concerns earlier in the year following an IPC audit the provider had arranged for further training for staff. Staff we spoke with demonstrated a good understanding of IPC including when to use PPE. Staff said there were hand wash stations and they understood the importance of good handwashing techniques. A staff member told us that carpets were being replaced with washable flooring this work was ongoing at the time of the assessment.

Observation

We observed dirty laundry on the floor in peoples bedrooms, bin bags left outside main door. Every room, including bathrooms, had very small white bins with lids which are not appropriate for clinical waste. This was identified on in the external IPC report and had not yet been actioned. Main bathrooms did have appropriate clinical waste bins. The bin store was not always locked and we saw lots of waste bags piled up next to bins store, the manager did not have a plan in place for how this would be addressed/collected. All toilets and bathrooms had soap and paper towels.

Processes

Cleaning records evidenced that cleaning was not always taking place as scheduled. There was not an appropriate system in place to deal with waste safely. Monthly infection control audits completed by the management team had failed to identify gaps in records and ongoing waste issue and include this in the action plan.

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Safe

Medicines optimisation

Overall Score

1 2 3 4

How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

People received their medicines as prescribed. One person told us that they received their medicines but they were later than they would like, they said the reason for that was that the home was short staffed. However, another person said they received their medicines on time and staff told them what they were for. We found no concerns with the timing of people's medicines but people's preferences should be considered in person centred planning which we did find needed improvement.

Feedback from staff and leaders

Staff had received training in medicines management. There were competent staff allocated to manage the ordering and organisation of people's medicines. Staff told us that when they identified people who were in pain senior staff acted quickly to administer pain relief. One staff member said "We won't let people be in pain at all."

Processes

The provider ensured staff that administered medicines had received training in medicines management and had their competencies checked. They had introduced systems to check people had received their medicines, but this did not always identify where 'as required' medicines had been administered but not always recorded. This had been resolved at the time of the assessment.

Well-led

Rating: Inadequate

Percentage Score: 32.00 %

▶ How do we score this?

Summary

This service is not well-led

Commentary

At the last inspection the provider was in breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this assessment the provider remains in breach of Regulation 17 and conditions of monthly reports to the Care Quality Commission (CQC) remain on the providers registration. There had been a high turnover of managers in the home. A new manager was in post that would need to listen and build trust with the staff team to ensure a positive culture. Systems and processes were not effective in identifying risks in the environment and actioning improvements. The provider had not maintained effective oversight of risk and People's needs, people had been exposed to risk of harm. Accidents and incidents had not been managed effectively. Progress on improvement was slow and the provider had been unable to embed and sustain improvements once external support from stakeholders was withdrawn. The provider had commissioned external support with improvements but this had not improved the quality of the service to date. The provider had not adhered to the conditions of their registration placed upon them at the last inspection.

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Well-led

Shared direction and culture

Overall Score

1 **2** **3** **4**

How do we score this?

Summary

Inadequate - This service does not maximise the effectiveness of people’s care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders

We were not reassured that there was always a positive culture in the home or between the staff and management team. There had been a high turnover of managers at the service. However, a new manager was in post who was keen to make improvements and build relationships with staff. This would need to be developed and embedded to build staff confidence and improve the culture in the home. One staff member told us, “We have meetings, loads of things discussed but no action really, things seem to get worse. There was a massive turnover of managers we hoped the new manager would change things but it’s just never happened.” A staff member said that not all staff are committed to care, they said they leave the building early and spend time on their phones instead of engaging with residents, they said, “The residents tell us they are ignored.” One staff member said, the management team did seem to be making changes which had been positive and they were putting money into things. They felt that care staff and team leaders roles could be developed and utilized further to contribute to the improvement of the service. The provider told us that retention of managers had been a challenge, but they were confident in the appointment of the new manager and felt that there would be positive improvements going forward.

Processes

The failure to accurately record accidents and incidents and staff witnessing events that they did not believe were recorded or actioned gave us some concern around potential for closed cultures within the service. The provider will need to ensure a more robust system is in place where staff feel that they are listened to and action taken when they raise concerns.

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Well-led

Capable, compassionate and inclusive leaders

Overall Score

1 2 3 4

▶ How do we score this?

Summary

Inadequate - This service does not maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders

Staff were not assured that management were monitoring all staff were delivering kind and compassionate care or ensuring people had basic items to ensure dignified and safe care. One staff member said. "We have told management that a lot of the residents don't have shower gel, we are washing them in shampoo or antibac soap as we don't have anything else, that's disgusting." Another staff member said, "We used to have Key workers who checked on things like clothes and toiletries, they would call family members for new clothes or shower gel, the home used to supply shower gel but don't any more." The staff member told us they were worried about the affects anti-bacterial soaps and shampoo on skin integrity. A staff member told us that residents were often heavily soiled at shift changeovers, they said staff use night pads consistently to reduce the amount of times continence pads needed to be changed and save time. Most staff told us there wasn't enough staff to meet people's needs.

Processes

There had been a high turnover of management at the service, the provider had commissioned a consultant to work with the service, however, the quality of the service had been inconsistent with improvements not sustained and embedded in practice. Action plans were in place but they evidence slow progress on improvement and had not identified and actioned issues in a timely manner. A new manager with previous experience was newly in place at the time of the site visit and is in the application process to be the registered manager for the service.

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Well-led

Freedom to speak up

Overall Score

1 2 3 4

▶ How do we score this?

Summary

Requires Improvement – This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders

Staff told us they felt confident to speak up with any concern but they did not always feel listened to or see action taken. One staff member said, "I do feel I can speak up and I have done but [they don't listen]." Another staff member said, "I have raised things, but they don't listen nothing has been done." One staff member said, "Not sure about what freedom to speak up is, but I feel confident to speak to managers. I have raised concerns about staff levels." Another staff member told us they had felt listened to.

Processes

We were not assured that the manager had a good understanding of a speak up culture. Managers or a person allocated as speak up guardian ensure that people who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken. This had not always been the case for staff in this home. The provider had a complaints policy for people that included details outside of the organisation where people could make complaints including the local authority and the local government ombudsman. There was a whistleblowing policy for staff guidance.

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Well-led

Workforce equality, diversity and inclusion

Overall Score

1 2 3 4

► How do we score this?

Summary

Requires Improvement – This service generally maximises the effectiveness of people’s care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders

Staff told us they did not feel they were always treated fairly, they said there were disparities in pay across roles that did not reflect workload and responsibility equally. There were some concerns that less experienced staff were not identifying issues that more experienced staff were, and they may need further support training to keep people safe and meet their needs. The manager planned to build positive relationships with the staff team. There was evidence the manager had consulted with staff to ensure their personal circumstances and caring responsibilities outside of work were considered when rostering for shifts.

Processes

More work was needed to ensure an inclusive culture where staff felt listened to and action was taken to improve the quality and the safety of the service.

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Well-led

Governance, management and sustainability

Overall Score

1 **2** **3** **4**

▶ How do we score this?

Summary

Inadequate - This service does not maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders

Staff shared their concerns with us about staff numbers and how this was affecting the safety and the quality of the service. One staff member told us, "I have made errors when I have been under stain & I worry this will happen again as I am distracted looking after multiple people, I reported this immediately but we don't have the staff to support." A person told us they had raised concerns at a residents meeting about staff numbers but was not reassured they would be listened to, they felt that the provider was reluctant to spend money on increasing staffing. We discussed staffing and deployment of staff with the provider who was relying on dependency tools and their own infrequent observations as a means of monitoring staffing numbers. The provider was advised by the commission that they must ensure they meet the conditions of their registration which were imposed upon them at our last

inspection to ensure adequate staffing or risk prosecution from the commission. Staffing had been an ongoing issue and was not resolved, therefore the conditions on registration remain. The provider reassured the commission that they had now deployed staff accordingly this would need to be continued and embedded in practice.

Processes

Although audits and action plans were in place they had failed to identify some of the concerns found during the assessment. For example concerns around staff numbers and the safety of the environment. Action plans that were in place evidenced slow progress, with some action outstanding for over a year. Provider observations and daily walk arounds had failed to identify that conditions on the providers registration in relation to staffing was not met. Risk assessments and care not implemented in a timely manner on admission and not reviewed and updated as people's needs changed. The provider implemented a new process post our assessment which meant new admissions would be overseen by a member of the senior management team to ensure staff had all the information needed on admission to keep people safe. These new systems would need to be continued and embedded in practice to ensure sustained improvement.

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Well-led

Partnerships and communities

Overall Score

1 **2** **3** **4**

► **How do we score this?**

Summary

Inadequate - This service does not maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

People’s care and safety needs were not consistently met. The provider had failed to embed an continuously sustain improvements. The support from the local authority following a suspension of placements in 2023 had been successful in initial improvements but these were not sustained once this support was reduced and a temporary suspension was imposed again following our site visit which has since been lifted. A infection control audit conducted by a partner agency in early 2024 found a number of concerns that had not been identified via the providers internal auditing systems. This had left people at risk of infection. The provider invested in improvements to comply when they received the outcome of the audit. However, see Vicky’s notes Health care services such as GP and chiropodist visited the home to support people as and when required.

Feedback from staff and leaders

The provider was aware that there was a need to improve the service by driving, sustaining and embedding improvement. Following our site visit the provider and operations manager told us they had implemented weekly progress meetings with the management team to push for action plan completion. The operations manager advised they would be actively present in the home for 2 days per week to support the manager with oversight of quality and safety.

Feedback from Partners

A partner agency told us that the provider and management team took feedback on board and worked with them to improve. However, once support was withdrawn the difficulty was to sustain and embed improvements. Another partner agency told us there had not always been a positive and professional culture within the home. However, they felt there had been some improvement with the new management team but there was still work to do to ensure people received high quality person centred care.

Processes

The provider did not have robust systems in place to sustain and embed improvements in the service.

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Well-led

Learning, improvement and innovation

Overall Score

1 2 3 4

► How do we score this?

Summary

Inadequate - This service does not maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Feedback from staff and leaders

Staff not consistently feel listened to or that lessons had been learned when things went wrong. Staff felt that the hand held devices provided quick access to peoples records which was helpful but there was still work to do to make sure information was accurate and up to date. Leaders were keen to cooperate with stake holders and started to make improvements post assessment to improve the safety and quality of the service. The local authority placed a suspension on new admissions to the service post our assessment until there was evidence of improvement. The suspension was lifted again once improvements were evidenced a short time later.

Processes

The provider and manager audits were not always effective in identifying concerns however a recorded mealtime observation which took place in April

had identified a number of issues with people's mealtime experience, some of which could have been addressed immediately. However, the analysis of the observation did not indicate that immediate action was taken, instead it advised that the management team would look at the meal time experience in May during a planned restructure. This had not been added to the providers rolling action plan to ensure this took place in a timely fashion. The rolling action plan reflected slow progress for example where issues with accuracy of information in peoples care plans, falls assessments and accidents and incidents forms had been identified, some as far back as March 2023 were recorded as still in progress.