CQC assessment report for Elmcroft Care Home

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	Read this section
Effective	Inadequate	Read this section
Caring	Inadequate	Read this section
Responsive	Inadequate	Read this section
Well-led	Inadequate	Read this section

Overall Service Commentary

Elmcroft Care Home is a residential care home with nursing provision, set over 2 units: Blythe and the General Nursing Unit (GNU). The service is registered to provide care for younger and older people, those living with dementia, and people with a physical disability.

At the time of our inspection, the service was also registered to provide care for people with a learning disability and or autistic people. The service was not supporting any people with these care needs, and the provider applied to remove this service user band during our inspection. At the time we announced our assessment, 46 people were living at the service. We carried out our on-site assessment on 7 May 2024, 9 May 2024, and 14 May 2024. A Pharmacist Specialist inspector visited the service on 28 May 2024 to review medicines management. Off site assessment activity started on 7 May 2024 and ended on 4 June 2024. We completed this assessment in response to concerns we had received about the service. We looked at quality statements relating to areas in safe, effective, caring, responsive and well-led. We identified 5 breaches of the legal regulations relating to person-centred care, safe care and treatment, safeguarding, governance, and staffing. We have told the provider they need to make improvements. In instances where CQC have decided to take civil or criminal enforcement action against a provider, we will publish this information on our website after any representations and/ or appeals have been concluded. 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 use 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

Whilst some people expressed they were happy with their care, our assessment found care did not meet the expected standards. We received mixed feedback from people using the service, with both positive and negative comments. We observed institutionalised practice on site, as whilst staff were kind and well-meaning they lacked the staffing numbers, training, support and guidance to deliver consistent support. 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. There were limited ways for people to spend their time in alignment with their own needs, ambitions and preferences, and care was largely task-orientated and not personalised to individuals. A person told us, “I really don't know what I'm going to get up to today. I'm fed up. I've really nothing to do.” Another person said, “Do I get visitors? No, not really. We just sit in here all day except for mealtimes.”

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Safe

Rating: Inadequate

Percentage Score: 25.00 %

Summary

This service is not safe

Commentary

We looked at all quality statements for Safe at this assessment. The service was not safe. This showed a decline since the last inspection. Risks assessments were poor or incomplete, including for serious safety concerns such as self-harm or suicidal ideation. Safeguarding systems and processes were not effective to protect people from abuse and neglect. Lessons were not learned to reduce the risk of reoccurrence when safety incidents occurred. People did not always experience safe pathways of care, and we received negative feedback from professionals who work with the service. Improvements were needed to ensure safe environments, including in

infection prevention and control. Improvements were needed to recruitment processes. People did not always receive their medicines safely and as prescribed. During our assessment of this key question, we found concerns about unsafe care and treatment, safeguarding and staffing which resulted in 3 breaches of the legal regulations. You can find more details of our concerns in the evidence category findings below.

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Safe

Learning culture

Overall Score

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

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

There was a failure to analyse and consider learning from incidents to improve people's experience of care. A person's daily care records showed they were upset by constant staff presence in their bedroom, but there was no recorded action taken in response. On 1 day, the person said to staff, "Why are you watching over me like a hawk?". Later the same day they became increasingly anxious, stating to staff, "I don't want to be watched over like a baby, get out of my room or I will call the police." Whilst the person was supported with 24 hour 1:1 care, the lack of learning about the best way to support them did not safeguard the person and placed them at risk of escalating distress.

Feedback from staff and leaders

Staff were not always aware of serious incidents which had taken place at Elmcroft Care Home to prevent repeat incidents and embed good practice from lessons learned. A person had an unwitnessed fall and sustained multiple rib fractures, but

post-fall observations were not consistently completed by staff, so the extent of their injuries were not noticed. A staff member told us, “There was an incident with [person], but I wasn’t there, so I don’t know the details.” Incident records showed another person had fallen after this and also had no consistent post-fall observations completed despite a potential head injury. The provider told us disciplinary action had been taken, and information shared with the wider team going forwards.

Processes

As the provider failed to identify issues and concerns, and there was poor oversight of accidents, incidents and safeguarding, there was no meaningful way in which staff could learn lessons from adverse events to reduce the risk of reoccurrence. Any recommendations or findings that were identified were not always actioned. This placed people at the continued risk of harm, including from potentially avoidable events. For example, audits identified concerns not all staff had practical moving and handling training and a lack of post-fall observations for suspected head injuries, but no effective action had been taken.

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Safe

Safe systems, pathways and transitions

Overall Score

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

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 received mixed feedback from people and their relatives as to whether referrals and transitions were planned and organised collaboratively. A person’s relative told us, “Staff will call a GP and other healthcare professionals if needed and will promptly make referrals if needed. I am not sure what may be in place for helping people who may have a mental health condition.” Another person’s relative said, “I have recently

only been told the evening before that [my person] has a hospital appointment the following day and I have asked for at least a few days' notice so that I can attend."

Feedback from staff and leaders

Admissions and discharges to and from hospital did not reflect joined-up care. A staff member told us, "We get no update about people when they return from hospital. We check them for bruises and pressure ulcers and record anything on a body map we take their vital signs. Nurses do the care records, but they are not updated or revised to show any changes in current needs."

Feedback from Partners

The provider failed to prioritise continuity of care and collaboration in relation to identifying concerns and making timely referrals, and we received negative feedback about staff knowledge and understanding of risks posed to people. A professional told us, “The interactions I have had with Elmcroft Care Home varies dependant on which member of staff is on duty. The care staff lack understanding about catheters, physical health, sepsis risks, UTIs, dementia, mental health conditions and how to accurately document events/concerns about a client in their care.”

Processes

Systems and processes in place failed to proactively consider, assess and manage risks to people when moving between services. There was a poor relationship with key stakeholders such as the GP practice, impacted by frequent changes to managers in post at Elmcroft Care Home. There was also an embargo on any new people being admitted to the service by health funders at the time of our assessment, due to safety concerns about catheter management and poor escalation by the service to other healthcare professionals.

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Safe

Safeguarding

Overall Score

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

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 assessed to require 24-hour 1:1 care were not safeguarded, sustaining serious unexplained injuries despite records stating they needed constant staff

supervision. A person with funding for 24 hour 1:1 care had sustained an unexplained fractured hip and an unexplained black eye in 2 separate incidents. There was also high level of unexplained bruising and skin tears amongst people more widely. A different person's relative showed us a photograph of their loved one with a black eye, and told us, "You ask if [person] is safe here early on, well look at this. How did that happen? Nobody here knows how, they all say, 'I don't know how that happened'. But it did happen, and I would like to know how [my person] has ended up looking like that."

Feedback from staff and leaders

Senior leaders did not demonstrate an understanding of local safeguarding requirements. The Nominated Individual told us they had not made a safeguarding referral in instances where a person attempted suicide or was assaulted by another person living at the service. Staff told us they were frightened to raise concerns due to a blame culture and were not confident concerns shared with leaders would be acted upon. A staff member told us, "I feel that if concerns were raised, they may be dismissed and not actioned. Information is still passed onto management." There were also no recorded de-briefs for staff who had been injured during incidents where people became distressed.

Observation

For people with 1:1 support needs, close observation and supervision including in people's bedrooms had not been considered as a trigger for distress or an infringement on their dignity, personal space and human rights. We observed people being constantly touched by staff providing 1:1 support, which restricted people's freedom of movement. Records corroborated our observations, such as an incident where 4 staff members were present to shower 1 person, which could be perceived be the person as restrictive, threatening and degrading. Staff were also not equipped to support people when expressing sexualised behaviour.

Processes

Systems and processes were not in place and operating effectively to safeguard people from potential abuse. There was no effective oversight of incidents, accidents and safeguarding concerns which meant they were not investigated and reported in a transparent way to reduce the risk of reoccurrence. We found evidence of multiple injuries such as bruising and skin tears which had not been properly recorded as accidents and incidents. We had to raise an individual safeguarding alert with the local authority for a person at risk of suicidal ideation, and a further organisational safeguarding alert regarding widespread poor practice. We identified concerns

relating to unexplained injuries and medicines which led the provider to raise 2 additional retrospective safeguarding referrals. During our assessment, the GP practice and health commissioners also made multiple safeguarding alerts.

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Safe

Involving people to manage risks

Overall Score

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

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

Whilst we received feedback that some people felt safe at Elmcroft Care Home, people and their relatives were not informed of risks, as risks were not assessed by the provider in a robust or timely way. People and their relatives were not always involved in the risk assessment and care planning process, with multiple people's relatives stating they had never seen a care plan. Other feedback showed relatives were not always assured about safety, with comments such as, "It's a good thing I'm here to visit regularly" and, "We've thought on some occasions to move [person] to another home."

Feedback from staff and leaders

We shared concerns with the senior leadership team about poor quality care planning and risk assessments. The provider responded to CQC feedback and sent an updated care plan for review as an example of proposed standards going forward. However, this document still contained unsafe information which placed a person at the risk of choking and was still not fit for purpose.

Observation

We observed some people expressing their emotions in a way which placed them and others at risk. There was a known history of some people leaving the building which could impact on their safety. We observed 1 person repeatedly trying exit doors but did not receive adequate staff support. We were informed the person later left the building on multiple occasions, as this risk had not been managed.

Processes

Care plans and risk assessments were generic, incomplete or inaccurate. This placed people at serious risk of harm, including from significant concerns such as suicidal ideation, sexual safety issues and self-harm. We had to seek formal written assurances from the provider during the inspection process to check people were safe but were provided with incomplete and inaccurate information. We informed the local authority safeguarding team of our concerns. Care plan documents also failed to assess and mitigate risks in relation to areas such as supporting people to move safely, catheter care and choking. Monitoring systems were not effective. Daily records did not show for people with indwelling catheters that their fluid intake and output was effectively monitored which would give an indication of potential blockage and retention. Whilst staff recorded the amount of fluid drunk, they did not record the amount of urine emptied from catheter bags.

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Safe

Safe environments

Overall Score

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

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 received mixed feedback from people and their relatives about the environment. A person’s relative told us they felt bedrooms needed to be updated. Another person’s relative told us, “The quality of the building has been improved”. However, we identified multiple safety issues in relation to the environment.

Feedback from staff and leaders

People were not always cared for in a safe environment designed to meet their needs. The provider accepted our findings and took steps to address this. However, it had not been identified or prioritised prior to our inspection, demonstrating a failure by senior leaders to recognise serious environmental risks. The Nominated Individual told us there were plans to improve the environment, including steps to make it more dementia friendly.

Observation

Wardrobes were not affixed to walls in people's bedrooms, including those who independently mobilise, placing them at the risk of potential crush injuries. Whilst the provider immediately took action to address this, it had not been independently identified. We also observed some fire escape walkways narrowed by the storage of equipment.

Processes

Ligature risks were not identified and assessed even where this was a known issue placing people at significant risk of harm. Personal Emergency Evacuation Plan (‘PEEPs’) did not cover all information required in the event of an emergency. A person who had a gate across their bedroom door did not have this information recorded in their PEEP to guide emergency services. This could pose an obstruction to evacuation in a fire, particularly if obscured by smoke. Some safety checks were in place in relation to the building, such as an external health and safety audit and fire checks. However, the provider’s own health and safety audits were not effective in identifying and acting on all environmental risks.

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Safe

Safe and effective staffing

Overall Score

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

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 received mixed feedback from people and their relatives about staffing. Whilst people were positive about regular staff who were described as being friendly and approachable, there were some concerns raised about the impact on people from staff deployment and lack of meaningful engagement. A person’s relative told us, “We were unhappy with [person’s] care here, [person] was just left in their bedroom. We tried to help getting [person] out of their room. Staff said they didn't have enough chairs, so we bought [person] one for the lounge and [staff] took it back into [person’s] bedroom.” Another relative expressed concern that short staffing had impacted on timely continence support.

Feedback from staff and leaders

Staff told us they were regularly overstretched and received limited support from management. No account of staffing levels was taken when planning activities outside of the home, and no extra staff were allocated. A staff member told us, “It’s really hard working here sometimes. We don't always get our breaks which is hard because then we're working for hours non-stop. It's mainly because we have to relieve other [staff].” Another staff member said, “It doesn’t affect the residents but us as staff we try our best to help the residents sometimes, we will sacrifice our breaks. We will sacrifice our time; we need to keep an eye on them. We keep the residents safe.” Another staff member told us, “I haven’t had any supervision. No appraisal either.” The provider told us they would review staff breaks and put supervisions in place.

Observation

We saw staff providing well-intentioned but intuitive care, and interactions showed a lack of staff awareness in areas such as dementia care, supporting people exhibiting distress, infection prevention and control and understanding modified diets. We saw care staff were also being asked by the provider to complete ancillary duties such as washing and wiping dishes instead of kitchen staff, further impacting on staffing levels. We also found a staff member responsible for 1:1 care asleep on duty during our inspection site visit. After the assessment, the provider told us they would take

action to reduce the length of shifts staff were supporting people with 1:1 care needs, to reduce staff fatigue.

Processes

The provider failed to ensure staffing levels, competency and training were adequate to meet the needs of people using the service. This meant people did not routinely have access to key elements of care, including meaningful leisure time, emotional support, encouragement to eat, adequate supervision to keep them safe and access to regular showers. Staff had no appraisals, and regular supervision was not in place to support staff development in their roles. Induction processes were poor, and we identified a new staff member with no on-site induction or mandatory training who told us they had researched dementia care on social media in place of any other guidance. Improvements were required to recruitment practices, to check new staff were safe and suitable for the role. The provider also failed to consider the impact on staff who were routinely working very long hours.

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Safe

Infection prevention and control

Overall Score

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

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

Whilst we received some positive feedback from people and their relatives, this did not reflect our observations of areas outside of public view. A person's relative told us, "[Elmcroft Care Home] is very clean and tidy". However, another person's relative told us, "At Christmas [person] dropped a biscuit on the floor, under [their] bed. I deliberately didn't pick it up, so waited to see how long it was before it was cleaned up. It took days and when they eventually moved [person's] bed it was very dirty where it was."

Feedback from staff and leaders

The approach to assessing and managing potential infection risks was not effective. We were informed by leaders the acting manager had come on site with symptomatic COVID-19 to collect a laptop, placing people living within the nursing home at unnecessary risk of acquiring infection. Staff were not clear on personal protective equipment (PPE) requirements as a result, with inconsistent use of face masks seen. Staff could tell us how to employ infection control measures such as the use of PPE, but this did not always correlate with our observations.

Observation

Whilst some areas of the service were clean and well-maintained, others were not. We identified concerns relating to sluice rooms, the laundry room, laundry closet and shared shower and bathrooms. This included unsafe waste disposal, clutter and items stored on the floor, paint peeling from walls and unclean shower chairs and drains. This placed people at the risk of infection. We observed a person's bedroom had a strong malodour on multiple days of inspection. Staff PPE practice was inconsistent and included staff members touching PPE face masks and serving food without performing hand hygiene, and a used face mask screwed up in a staff member's pocket.

Processes

People were not protected as far as possible from the risk of infection because the provider failed to ensure premises and equipment were kept consistently clean and hygienic. Audits did not identify our findings in relation to poor maintenance and infection prevention and control concerns. Where issues were noted in audits, such as the poor condition of sluice rooms, no action was taken. There were also no detailed cleaning schedules for staff to follow. The provider told us they had

commenced works to improve the sluice rooms and laundry to ensure they were clean and fit for purpose, following our feedback.

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Safe

Medicines optimisation

Overall Score

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

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 mostly supported to take their medicines correctly and at the right time. This was recorded on their electronic medicines administration record (eMAR). Individual needs and preferences were considered during medicines administration rounds. Staff treated people with dignity and respect. However, 1 person requested pain relief and staff were unable to respond appropriately. Analgesia had not been prescribed for that individual and there was no mechanism in place for staff to be able to administer a homely remedy. Another person required a review as they were experiencing difficulty in swallowing, but this was not reflected in their care plan.

Feedback from staff and leaders

Staff told us there was information available to them which enabled them to manage medicines safely and effectively and they had received medicines training. Staff told us they did not receive any feedback or learning from incidents. The Nominated Individual told us they had identified a person given medicine they were not prescribed following our request incidents were reviewed, leading to a safeguarding referral being made. Staff from the GP practice visited weekly to review people. We were told there were some issues with completing electronic records due to internet connectivity. A staff member said, “Sometimes there are issues with the internet

when doing MARs, they are delays in the documentation. Sometimes in a week it can happen 2-3 days.”

Processes

The service did not always have systems for appropriate and safe handling of medicines, but actions were taken promptly to rectify the issues once identified by inspectors. Allergies were missing from the electronic medication administration records (e-Mars), this was actioned on the day of our inspection. Authorisations for the safe and appropriate administration for end-of-life medicines were not always in place or hadn’t been reviewed recently. There was no access to homely remedies so staff couldn’t respond in a timely manner to minor ailments and the recording of transdermal patch applications was poor. There were also no contingency measures for e-MARs in case of internet outage. The provider told us they had acted to put this in place. However, issues identified at our inspection had not been dealt with through the provider’s own processes, such as medication audits.

Effective

Rating: Inadequate

Percentage Score: 25.00 %

Summary

This service is not effective

Commentary

We looked at all quality statements for Effective at this assessment. The service was not effective. This showed a decline since the last inspection. Assessments were completed by the service, but this did not translate to person-centred, effective care plans. This included a failure to assess the impact of specific health conditions and need for social and emotional support, including in relation to people's mental health needs. There were insufficient staff available to support people to eat at mealtimes, and care was task-led. Whilst people without capacity received an assessment on their ability to make decisions, there was a lack of choice more widely for all people

living at the service. This impacted on people's quality of life. During our assessment of this key question, we found concerns relating to staff support and training, resulting in a breach of the legal regulations. You can find more details of our concerns in the evidence category findings below.

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Effective

Assessing needs

Overall Score

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

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 and those important to them were not always involved in the planning of their care and support needs. Feedback showed there was a lack of consistent user-involvement in the assessment and care planning process.

Feedback from staff and leaders

We gave feedback that assessments and care plans were not sufficiently detailed, accurate or personalised to people’s needs. A staff member told us, “We would like to know more about the backgrounds of each of our residents, like what they did for a living where they are from, children, interests and so on and what activity they would like but I haven't seen anything like that yet.” The provider told us they would give care planning training to staff and sought to update care plan documents, including seeking input from people and their relatives on interests and life history.

Processes

Assessments completed by the service failed to demonstrate effective, safe, and person-centred care planning. This included for people with highly-specific needs relating to their mental health or dementia conditions, which required specialist support and guidance. We raised concerns relating to a lack of assessments for people at risk of suicidal ideation or self-harm. The provider had also not robustly assessed whether they could meet the needs of people with higher support needs they had admitted into the care home setting. This placed people at risk of their needs not being met. Oversight processes failed to identify when care plans were not updated in a timely way, for example to record if there had been a safeguarding concern.

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Effective

Delivering evidence-based care and treatment

Overall Score

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

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

Although some people gave positive feedback about the quality of meals, people's nutrition and hydration needs were not consistently met. A person's relative said, "I don't think [my person] is getting much water and not eating much. So, like the other day [person] was given the choice of 2 meals and chose omelettes. Well [person] is not able to make those choices anymore. Anyway, [person] really doesn't like eggs and of course didn't eat it. [Staff] should be aware of things like that, and they don't seem to encourage [my person] to eat, they just take the food away." Another person told us, "I would sometimes just like a cup of plain water, but you can't find any here, there's only squash on offer." Menus were not always accurate and were decided at corporate level without evidence of people's input. A person's relative said, "[My person] is not getting what's on the menu."

Feedback from staff and leaders

Staff expressed concerns about food provided for people. A staff member told us, "[People] had fruit today, but this is today because you (CQC) are here. I don't remember when we last had proper fresh vegetables." The staff member also told us, "Diabetic people often go without a pudding. There are no snacks for people at risk of choking. We have to pour tea on a biscuit and scrape it up with a spoon." Another

staff member told us monitoring of food eaten was completed inaccurately after meals had been cleared away, as “[Staff] should leave the plate on the table. It is done from memory; it is not seen.” The provider told us they had purchased adapted crockery and cutlery to support people to eat.

Processes

We observed there were not enough staff to support and interact with people left to eat independently, and therefore they did not receive the encouragement or practical help they needed to eat more. As a result, some people ate very little of what they were served. Concerns with mealtime experience were identified at our last inspection in 2022 and had not been resolved. This had not been identified by the provider through processes such as mealtime audits.

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Effective

How staff, teams and services work together

Overall Score

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

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 did not experience effective care, as staff did not have the information required to consistently work well with one another or other system partners. This included in relation to appropriate escalation of concerns and referrals to other professionals. For example, a person’s relative told us, “My [person] was recently admitted to hospital after I noticed [they] didn’t look well, and [person] was diagnosed with pneumonia and sepsis. I worry if staff would have noticed if I had not visited that day. However, staff are good with calling out a doctor.”

Feedback from staff and leaders

Staff did not have access to the information they needed to assess, plan and deliver people's care, treatment and support. Staff described a lack of information sharing and fractured internal staff teams, which impacted on people's continuity of care. A staff member told us, "We don't have proper handovers, its word of mouth. I was dishing up breakfast for one resident and got told, 'Oh no, they're in hospital'."

Feedback from Partners

We received consistently poor feedback from other stakeholders about the service, both in terms of staff working with external parties and with one another. A professional who works with the service told us, "Staff: They seem, very vague when entering the building, preoccupied in what they are doing and not very willing to help. When asked, will reluctantly assist, point you in the right direction and quickly scurry off in another direction before being asked another question. The Actual Area I Needed: No-one knew what anyone was doing, or where anyone was. No job structure, very mish mash. The staff on duty didn't know what the others were doing. 'Where is so and so?' and 'What is so and so doing?' could be heard."

Processes

Processes were not in place to ensure accurate information about people's health, care and support needs were recorded so this could be shared with the staff team and health and care professionals when required. Systems did not support staff to work together to provide safe care. A staff member told us, "When you get new staff, they should have moving and handling [practical training]. This is why we are getting lots of bruises. There is no manual handling person here."

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Effective

Supporting people to live healthier lives

Overall Score

1 2 3 4

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 empowered and supported to manage their own health, care and wellbeing needs. A person’s relative said, “When [person] first came here [person] was walking with a frame, but because [person] was left in their room and bed for so long, they are no longer walking at all. I've asked [staff] to get [person] out of their room more and walking but it hasn't happened and now we've noticed how weak [person] has become.”

Feedback from staff and leaders

Whilst the provider made referrals to other professionals to support people with their health needs, information and recommendations were not always documented in people’s records to guide staff. This included recommendations from professionals such as specialist Parkinson’s Disease nurses, or the community mental health team.

Processes

Processes were not in place to focus on identifying risks to people's health and wellbeing early on, or how to support people to prevent deterioration. For example, staffing calculations did not consider any extra support required for people's emotional and psychological health.

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Effective

Monitoring and improving outcomes

Overall Score

1 2 3 4

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 did not consistently experience positive outcomes including in relation to their quality of life. For example, whilst we saw some evidence of group activities for people led by the activities co-ordinator, other people such as those cared for in bed did not have the same experience. Some people’s relatives expressed concerns about a lack of enrichment and stimulation for people, including those living with dementia. A person’s relative told us they felt people were, “Just sitting.” Another person’s relative said, “I come in every day except Sundays and have noticed [my person] get no stimulation at all and [person] needs it because they are in their room all the time, but [staff] never seem to come in.”

Feedback from staff and leaders

The provider told us they reviewed metrics relating to aspects of people’s health and care needs at daily flash meetings, such as fluid intake. However, there were no

effective approaches to monitoring and supporting people's wellbeing or the impact of wider health needs.

Processes

There was a lack of effective processes for monitoring people's care, treatment and outcomes to ensure continuous improvements. This included in relation to daily care notes, which were task-led and did not provide any opportunity to review and improve metrics relating to quality of life. People did not have the opportunity to set out and document their own aims, ambitions or metrics for success and a good quality of life to ensure consistently positive outcomes.

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Effective

Consent to care and treatment

Overall Score

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

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 did not always experience care in a way which upheld their right to privacy, freedom of movement and human rights. This included people with 24 hour 1:1 care being observed at all times, including when asleep or in the bathroom, without a robust plan in place setting out why this level of restriction was necessary.

Feedback from staff and leaders

Staff told us they were committed to seeking people's consent and offering choices. A staff member told us, "Residents are given choice of what to eat and where to eat. Some people like to be in their rooms, or in the lounge, so we ask every day." However, we found staff did not always have the training, support or guidance from the management team to provide care to people living with dementia, or with mental health needs, in a person-centred way. This was particularly the case for people with higher support needs and impacted on people's quality of life.

Processes

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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. The service was not working within the principles of the MCA. Mental capacity assessments were in place for people where required, and there was

evidence DoLS had been applied for. However, the provider's own systems failed to identify indicators of staff practice which did not represent the least restrictive option or could constitute institutionalised care.

Caring

Rating: Inadequate

Percentage Score: 25.00 %

Summary

This service is not caring

Commentary

We looked at all quality statements for Caring at this assessment. The service was not caring. This showed a decline since the last inspection. Staff reported a closed blame culture and told us morale was extremely poor. Staff told us they were frightened to speak up and did not believe action would be taken by leaders if they raised concerns. This impacted on their ability to provide a consistently caring service. Staff were observed to have positive interactions with people and spoke about them in a kind and caring way. However, people's individual needs and preferences were not well understood. Staff also did not have sufficient guidance to respond to people's immediate care needs, to reduce the risk of avoidable distress, pain, or discomfort. People's dignity was impacted, as there were insufficient staff to facilitate regular showers in line with people's preferences. There was a lack of user involvement in care planning, including information on people's life histories, aims and ambitions. During our assessment of this key question, we found concerns about person-centred care, which resulted in a breach of the legal regulations. You can find more details of our concerns in the evidence category findings below.

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Caring

Kindness, compassion and dignity

Overall Score

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

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

Although people and their relatives told us staff were kind, staff were unable to always treat people with compassion and dignity in their day-to-day interactions despite their best efforts, due to the poor management and running of the service. A person's relative told us, "Care workers are so lovely, so passionate." Another relative said, "Staff are genuinely kind." However, 1 person told us they had not had a shower for 3 weeks as, "[Staff] are very bad for showers. Well basically, the basic care is okay but getting showers and my hair washed I have to fight for it." Records

confirmed what the person had told us. When asked by inspectors when they saw staff, another person told us, “Well, when I need changing. When I need feeding.”

Feedback from staff and leaders

Staff told us they were committed to supporting people kindly and respectfully, and expressed upset and demotivation following management decisions which prevented them from consistently doing so. A staff member said, “We are only giving the basic care. I can’t remember the last time we washed someone in the morning, and we had washed all their legs and their feet.”

Feedback from Partners

Partners expressed concern at how people's personal care needs were not always met to ensure their dignity. A professional who works with the service told us, "The nurse I spoke to today knew her residents. However, when personal care was discussed in detail if the resident gets agitated or worse and the resident declines a shower or bath, it would appear non-pharmacological approaches are not used. The resident I went to see had only had maybe 1 shower in the last couple of months according to the nurse."

Observation

Whilst staff spoke about people kindly and with compassion, and we saw positive interactions where staff had time, systems were not in place to allow staff to deliver a consistently caring service. This included staff support, training and deployment at management level. We observed staff unable to spend meaningful time with people. This impacted on people's dignity, for example lack of access to regular showers.

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Caring

Treating people as individuals

Overall Score

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

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 individual needs and preferences were not always understood and reflected in their care, treatment, and support. A person told us, “You never know what's going on but nothing much, same today. Sometimes, not very often, we've been out in the coach to places but not recently.”

Feedback from staff and leaders

We raised our concerns with the provider about the lack of individualised care. The provider told us they had commenced work to understand people's interests and backgrounds and were seeking additional dementia training for staff.

Observation

We observed care was institutionalised, and people did not have access to a wide range of leisure activities personalised to their interests. For example, on the first day of inspection there were colouring sheets placed in front of people, but there were not enough staff to support with this and people showed a lack of interest. Memory boxes outside of people's bedrooms had not always been filled to show about the person's character and interests or help them to orientate themselves to their own room.

Processes

Processes were not in place to promote and take account of people's strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics such as disability. Care documents did not always accurately reflect how individual people preferred to communicate, and in some cases used negative and disrespectful terminology such as describing a person's speech as 'loud and shouting'.

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Caring

Independence, choice and control

Overall Score

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

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

Feedback did not demonstrate how people felt empowered and able to employ independence, choice and control over their own care and treatment. A person’s relative told us, “When [person] came here, we didn't really have any choice in the matter. [Person] had been in hospital and the staff there didn't feel [person] would be safe or able to be at home anymore and [person] really needed 1:1 care.” Another person told us, “This is not the care home for me.”

Feedback from staff and leaders

We informed the provider people's care records did not have sufficient information to ensure they had access to relevant activities of interest and the local community, to promote and support their independence, health and wellbeing. The Nominated Individual told us they had asked people's relatives for information on people's interests but had not been given any information. This showed a lack of insight and accountability for the failure to explore people's interests by the management team.

Observation

We saw people were able to have visitors in line with national best practice guidance, in order to maintain relationships with family and friends. However, people did not have choice and control in relation to flexible access to the community and leisure activities both inside and outside of the home.

Processes

There was a lack of user involvement evidenced in care planning. We also did not see people having a choice. Care plans did not provide detailed information on how staff should support people's choices or to meet people's ambitions and goals. Care records did not say how the service was supporting people to be more independent.

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Caring

Responding to people's immediate needs

Overall Score

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

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

As there was a lack of understanding about how to meet people’s needs, staff did not have guidance to meet them to reduce distress or anxiety. Records showed staff did not have plans in place for people when extremely upset and expressing their emotions, and ad hoc attempts to comfort people did not always work. For example, we saw staff make promises to people that could not be kept, in lieu of any other guidance.

Feedback from staff and leaders

Staff told us there were not enough staff in place to meet people's immediate needs, and they had raised this with leaders, but no action had been taken. Staff shared concerns about supporting people in a timely way if they rang the nurse call bell from their bedrooms, as well as ensuring the safety of people in shared spaces at the same time. The Nominated Individual told us they considered the service to be 'overstaffed'.

Observation

There were insufficient staff suitably deployed to meet people's immediate needs, which meant they were not always anticipated quickly to reduce discomfort or distress. We also found there were no homely remedies on site, so pain-relief was not readily available unless prescribed, delaying support for people in pain.

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Caring

Workforce wellbeing and enablement

Overall Score

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

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 did not feel valued, and reported bullying, harassment and racial discrimination by leaders, including threats to revoke Home Office Sponsorship Licences. A staff member told us, "Staff morale at the moment is very down because of new management, they are very unfriendly. I pray that I would not be in trouble. I'm here on a sponsorship so very worried about getting things wrong. One time the

[management] said, ‘I don’t care about your sponsorship. If I can’t work with you, you can go, there’s the door’.” Another staff member said, “We are treated like the bottom of a shoe. We are frightened to report anything.” And “We have had 7-8 managers. They [the provider] puts so much on the new managers at once. [Managers] come in here, they were talking to us like we were ‘this big’, shouting at us. They were really rude; they still are rude. They are only nice when CQC are here.”

Processes

The provider set up a HR clinic in response to concerns raised by inspectors about staff culture and shared a helpline for staff. However, basic support systems were not in place for staff such as regular supervision or team meetings to help them share any worries. The necessary resources and facilities for safe working were not in place, including access to regular breaks. Records showed some staff routinely working 70-hour weeks. Some supervisions carried out by a previous manager showed a punitive approach to discussions with staff, with comments such as, ‘It is abuse to speak your language when looking after residents’ and ‘We should not tolerate bad practice amongst ourselves and don’t underestimate what will happen if you are caught.’ Records showed staff were regularly physically assaulted by people expressing their distress, but there was no support provided by leaders.

Responsive

Rating: Inadequate

Percentage Score: 25.00 %

Summary

This service is not responsive

Commentary

We looked at all quality statements for Responsive at this assessment. The service was not responsive. This showed a decline since the last inspection. People’s care, treatment and support did not promote equality, remove barriers or delays and protect their rights, including those people living with dementia or other protected characteristics. People did not feel empowered. This was reflected in people’s care, treatment, and support, which was delivered intuitively by staff rather than following robust training and plans. Information was not always up to date, accessible or available for review. There was an inconsistent approach to seeking people’s views

on the quality of care, which excluded those unable to complete a written survey. A complaints policy was in place, and the service had received some compliments. End of life care planning required improvement. During our assessment of this key question, we found concerns about person-centred care, which resulted in a breach of the legal regulations. You can find more details of our concerns in the evidence category findings below.

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Responsive

Person-centred Care

Overall Score

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

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 did not have access to consistently personalised care, and we received feedback from people they were bored and had limited ways to spend their time. A person told us, "Look, I loved gardening at home and am really fed up today, bored. They don't do gardening here and there is loads of space out there. I can't be the only one who likes it. Yes, gardening would be nice, give me something to do. What we need is easy gardening like raised beds, but they've got none."

Feedback from staff and leaders

Resources were not always available to meet people's individual interests. The Nominated Individual told us of plans to improve the outside areas available to people, including new raised beds and a sensory garden. A new activities co-ordinator had also just started at the time of assessment.

Observation

Established staff knew some people's preferences and needs, but care was intuitive and not informed by care plans. This included a failure to ensure people who use services and those close to them (including carers and dependants) were regularly involved in planning and making shared decisions about their care and treatment. We observed a married couple were placed on separate units. As both parties were unable to mobilise independently and key code barriers in place, staff presence was required to enable them to see one another in a supported way. This was only put in place once raised by inspectors.

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Responsive

Care provision, Integration and continuity

Overall Score

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

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 received mixed feedback from people about continuity of care provision, including communication within the home. A person’s relative told us, “What is lacking here I think is communication between the care workers and staff in general. I'm told they have an exchange board in the office but one of the care workers said, ‘We never use it’. So, they don't make the best of it. That would help transfer current information about the residents.” However, another person’s relative said, “If my [relative] needs a healthcare professional or a hospital referral, staff will make it.”

Feedback from staff and leaders

Staff told us they did not have good continuity of care and integration within the care home setting and did not know people living on units they did not usually work on. When asked whether any people had a specific health condition, a staff member told us, “I’m not sure, I will have check with the manager. I don’t think so. As I told you, I work on that side [the other unit]. I need to be here today. A lot of residents here are new.” Another staff member expressed anxiety at not being able to give relatives an accurate update if working on an unfamiliar unit.

Feedback from Partners

System partners told us there was a lack of flexible, joined-up care for people. A professional who works with the service told us, “Most times when the care home sends us a referral, we are struggling to triage it over the phone, as the phone goes unanswered, or we are being told that there is no one to talk to. Whenever we are asking [staff] to call us back, they don’t. This makes triaging the referrals, especially urgent ones, extremely difficult.”

Processes

Systems and processes were not in place to ensure people’s care and treatment was delivered in a way that consistently met their assessed needs, in a co-ordinated and responsive way. This included a lack of oversight of the difficulties in consistent communication experienced by staff, families and professionals who work with the service.

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Responsive

Providing Information

Overall Score

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

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

Due to poor governance, oversight and care planning, people could not always get information and advice that was accurate, up-to-date and provided in a way that they could understand, in alignment with their communication needs. Some people’s relatives told us they had difficulty getting through to the service over the telephone. However, others felt information was communicated in a timely way.

Feedback from staff and leaders

People and their representatives did not always have access to information that was up-to-date, accessible, safe and secure. On day 1 of inspection, the provider was unable to supply any of the care plans requested for review by inspectors, and other documents were not available until late in the day. The Nominated Individual told us this was because of internet issues and manager sickness. However, there were no contingency measures in place.

Processes

Some people’s care plans set out their communication needs such as glasses or hearing aids. Pictorial menus were available for people, including those living with dementia. However, we found these to be incorrect and did not always relate to the menu for the day.

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Responsive

Listening to and involving people

Overall Score

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

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

Methods for seeking and acting on people’s views were not always accessible. People were not always being supported to give a view on their care. We received mixed feedback from people’s relatives about whether they knew how to make a complaint if required, and who to direct complaints to. The service had received some compliments and positive online reviews.

Feedback from staff and leaders

Some staff told us their concerns about people’s care were not always acted on, or they did not have confidence in leaders to investigate issues robustly. This meant it would be difficult for them to advocate for people to improve their experience of care.

Processes

Satisfaction surveys had been carried out by the provider to gather people’s views and experiences, and the results returned from the survey were overall good.

However, the results of the survey did not say how many people responded, or if anyone needed any support to complete it. There was no evidence to show how the service reached out to people without the capacity to respond to the survey. A complaints policy was in place, although we saw a copy of the complaints procedure on display with a previous manager as the point of contact.

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Responsive

Equity in access

Overall Score

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

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 could not always access care, treatment and support when they needed to and in a way which promotes equality, removes barriers or delays and protects their rights. This included being physically able to access shared parts of the care home due to mobility needs. A person's relative told us, "The main problem is if [staff] ask [my person] if they want to get up, [my person] will say no, but they (staff) need to find ways around that. We feel [person] needs to get up and out more." And, "There must be ways to get residents up and out. In the year [my person] has been here [they've] been in the lounge 3 or 4 times." However, we received some positive feedback from others to say staff encouraged people to join social areas.

Feedback from staff and leaders

Leaders were not alert to discrimination and inequality, even within their own staff teams. This did not demonstrate a service focused on meeting best practice quality standards, including awareness of equality and human rights. Multiple staff reported racial discrimination, with overseas staff not being listened to by management. A staff member told us of this concern, stating, "I don't know if it's safe saying this." This had

the potential to impact on people of different cultural backgrounds living at the service.

Feedback from Partners

Partners told us people experienced delays in accessing support in relation to their health needs. A visiting professional told us, "'I visited a patient last week in Elmcroft Care Home and staff were busy. They asked a care worker to assist with the patient I was seeing but after I had seen the patient, I needed to speak to the senior on shift to advise them that the patient looks like [they] have conjunctivitis in both eyes and [staff] need to raise this with the GP as soon as possible, as [person's] eyes were discharging green and weeping. I was very surprised that the care home had not noticed this themselves and called the GP out."

Processes

Processes were not in place to improve access for people likely to experience barriers or delays in accessing their care. People’s feedback was not used to ensure equity of access for all, including those people living at the service with physical disabilities, mental health needs or varying stages of dementia.

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Responsive

Equity in experiences and outcomes

Overall Score

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

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 and their advocates were not always able communicate their views about the service in a way which proactively considered equality characteristics. This impacted on tailored support provision, and outcomes for people. A person’s relative told us, “[Person] has been given range of exercises to help [their] movement as they have been in bed for 6 weeks, but I feel like I'm constantly banging on about it as they're not happening here. It's not difficult for [staff] but important for [person’s] mobility. Since [person] has been here, they have lost weight, and of course muscle wastage has taken place because [person] is not mobile.”

Feedback from staff and leaders

Leaders failed to demonstrate how they pro-actively sought out and listened to information about or from people most likely to experience inequality in experience or outcomes. This meant care, support and treatment could not be tailored in response to ensure equity and reduce the impact of barriers to care.

Processes

The provider was failing to meet its own CQC provider information return response (PIR) on how they met human rights principles in the service. This stated, ‘We support, encourage and monitor staff to ensure the delivery of high standards of care to ensure our residents feel safe, empowered and assured that they and their wishes are respected.’ This was not happening in practice, for example, there was limited information to guide staff on support for people living with dementia.

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Responsive

Planning for the future

Overall Score

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

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 received mixed feedback on people’s experiences around death and dying. Whilst the service had received some compliments from relatives for supporting people with end-of-life care, not everyone using the service had their spiritual and emotional needs met to reduce the risk of low mood. A person we spoke with told us,

“I’m 87 now so hopefully not long left.” We asked the local authority safeguarding team to carry out a welfare check with the person as a result.

Feedback from staff and leaders

Staff received training in end-of-life care and expressed their dedication to compassionate care. However, they were not supported by leaders to deliver this due to lack of personalised care planning guidance on how people wished to be supported.

Processes

Some information relating to end-of-life care was contained in care plans, but this required further personalisation to ensure people’s spiritual and emotional needs were met in a holistic way. For example, 1 person’s care plan stated, ‘Meet the specific end of life wishes of the service user’ but gave no further details. This was a continued concern from our last inspection, and the provider had failed to make improvements in this area. Information was recorded such as whether DNACPRs were in place.

Well-led

Rating: Inadequate

Percentage Score: 25.00 %

Summary

This service is not well-led

Commentary

We looked at all quality statements for Well-led at this assessment. The service was not Well-led. This showed a decline since the last inspection. The service failed to operate safe and effective governance systems, and processes in place such as audits were incomplete or of poor quality. The provider did not independently identify risk which impacted on people’s safety and welfare. As there was limited oversight of accidents and incidents, this meant the service could not be open and transparent when things went wrong. Feedback from system partners showed the management

team failed to seek and act on relevant feedback to ensure the quality and safety of care. Legal requirements were not consistently met, such as the failure to submit statutory notifications to the CQC. Staff reported a poor and closed culture, with staff factions and allegations of bullying, harassment and racial discrimination. There had been a high management turnover at the service which impacted on shared vision and direction to make improvements. During, or shortly after, our inspection all of the management team left the organisation. During our assessment of this key question, we found concerns about governance systems, which resulted in a breach of the legal regulations. You can find more details of our concerns in the evidence category findings below.

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Well-led

Shared direction and culture

Overall Score

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

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

A new management team had just been recruited including a home manager, a deputy manager and a clinical lead. Whilst new managers told us they were being inducted there was no formalised management induction plan. The new manager said they had looked up the service's last inspection report and confirmed the provider had not shared a development plan to inform them of the provider's direction and expectation. The manager said, "This is my 5th week and there are things I want to look at and potentially change." A staff member told us, "This place used to be so nice, it was immaculate. But not now. The main problem is they can't seem to keep the managers, they keep changing. I think we've had 5 or 6 in the same number of years or less." A new Nominated Individual and home manager were appointed following this assessment.

Processes

There had been multiple different managers in short succession, leading to an inconsistent approach to management of the location without a clear vision for improvement. The provider failed to actively involve staff for the purposes of continually evaluating and improving the service, which meant staff were not aware of any changes or improvement in the way they were working. During the inspection or shortly after, the home manager, deputy manager, clinical lead and provider's Nominated Individual all left the organisation.

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Well-led

Capable, compassionate and inclusive leaders

Overall Score

1 2 3 4

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

Leaders did not have the knowledge and capability to ensure the service was well-run and risks well managed. For example, the new manager was not aware of the CQC's Right Support, Right Care, Right Culture guidance for supporting autistic people and or people with a learning disability, despite a recommendation made at the last inspection to increase awareness in this area. The provider applied to have this specialist service user band removed from its registration during the inspection.

Processes

Despite having the support of consultants, the provider had failed to make, sustain and embed any improvements since the last inspection. There was no cohesive or credible service improvement plan, and multiple versions were supplied piecemeal throughout the inspection process. Management visibility was poor, and we received feedback people's relatives did not always know who the manager was.

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Well-led

Freedom to speak up

Overall Score

1 2 3 4

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 told us they did not have the freedom to speak up. A staff member told us, "We are here to work as a team but there isn't really teamwork. Some of my colleagues lack confidence to speak out, if you are the one to always talk you can be seen as not good… It's not easy to make suggestions." Another staff member said, "I try talking but it's a waste of my time. I say and nothing happens. And then it's always [my] fault." Only superficial action was taken in response to staff concerns when we shared these themes with leaders. Whilst a HR clinic was set up and a staff helpline shared, the Nominated Individual told us all concerns were resolved within 1 day, which was not a realistic timeframe to address embedded issues relating to staff culture.

Processes

The management team did not model an open and honest approach. We identified the provider either could not immediately supply, or had updated, many care plans and other documents after we had requested to see them, which was obstructive and did not demonstrate a transparent approach to the inspection process. Processes were not in place to reduce the risk of a closed culture forming.

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Well-led

Workforce equality, diversity and inclusion

Overall Score

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

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 described an extremely poor and bullying culture, which was not inclusive or fair. A staff member told us, "The staff feel bad, [the management] approach is too harsh so mentally we become traumatised. When I come to work, I feel nervous and then you feel like you won't get that respect or support. You are being more careful so that [managers] don't shout at you." Another staff member said, "I find the new manager has a heavy approach using tactics like shouting at staff and I think she would get more productive staff if she wasn't like that. She is very dismissive and unapproachable and that's what brought the morale down."

Processes

Although there were processes in place such as the provision of equality and diversity training for staff, this did not translate into practice. There was a failure by the provider to implement effective systems to assess, monitor and record the impact of training to ensure it was embedded and to ensure a fair culture. Staffing skill mix,

working hours and support was not proactively considered. This meant staff were not empowered to provide the care meeting the expected quality standards.

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Well-led

Governance, management and sustainability

Overall Score

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

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

Feedback from staff and leaders across the organisation at all levels did not provide assurance or evidence of robust, effective or well-embedded governance and oversight measures. The integrity of information and data was not consistently assured. This had an impact on people using the service. There was no effective leadership to oversee and direct staff on each shift, and roles and responsibilities were not clearly defined. Multiple staff expressed serious concerns about poor management structures. A staff member told us, “It is just diabolical.”

Processes

Quality assurance processes were poor and systems were not well established and monitored to ensure safe and good quality care. There was no evidence of effective provider oversight in areas such as safeguarding, staffing, culture, or accidents and incidents. Audits were insufficiently detailed to address issues of concern, and the provider failed to act promptly in response to any issues identified. The provider failed to meet basic legal and regulatory requirements such as submitting statutory notifications to the CQC in cases of serious injuries and allegations of abuse.

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Well-led

Partnerships and communities

Overall Score

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

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 and those important to them, were not always able to work in partnership with the service and be fully involved in their own care. People told us there were

relatives' meetings, but not everybody had attended to share their views and they did not get minutes or updates on agreed actions. A person's relative told us, "Communication could be better". Another person's relative said, "It's hard for me to say how good or bad it is here because we've had no experience of places like this." People's feedback had been gathered but not analysed to create an action plan.

Feedback from staff and leaders

Leaders were not always open and transparent in collaborating with all relevant external stakeholders and agencies. There were systemic failings in the leadership, governance and safety of the service. The Nominated Individual showed a lack of awareness as to the impact on people of this or validity of stakeholder concerns, stating, "This home has a lot of historical issues. People always jump to the worst-case scenarios." Staff told us there were no regular team meetings to share their views.

Feedback from Partners

The service did not consistently work in partnership with key organisations to support care provision, service development and joined-up care. A professional who works

with the service told us, “During my visits, the staff appeared to be in need of training in managing and caring for not only [person living with dementia] but the other service users at the care home.” Following our inspection, the provider sought advice and support with the local authority quality improvement and safeguarding teams, as well as stakeholders from health.

Processes

As the provider had failed to identify serious incidents, this meant investigations were not always carried out to determine any wrongdoing and any subsequent improvements required. The provider was therefore unable to be open, honest and transparent with service users and their relatives, providing an apology as necessary under its Duty of Candour responsibilities. This also meant they were unable to engage with people and their advocates to drive improvements.

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Well-led

Learning, improvement and innovation

Overall Score

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

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

Feedback from staff and leaders did not demonstrate a focus on continuous learning, innovation and improvement across the organisation and the local system. The provider did not have an effective system in place for reviewing and investigating safety and safeguarding incidents and events that go wrong. Safeguarding concerns were not always recognised and appropriately reported, which impeded learning from serious safety events. The provider failed to look at its own practices to see where improvement could be made to ensure service user safety was not compromised.

The provider failed to seek advice or guidance from the local authority as to safeguarding thresholds for accidents and incidents.

Processes

Governance processes were not well developed, and the outcomes and impact of any action taken was not monitored, placing people at risk of harm and continued poor care. The provider failed to demonstrate how the service learns and improves, including from serious incidents and safeguarding matters. We raised an organisational safeguarding alert with the local authority, so additional support and training could be provided by system partners.