Avery Homes (Nelson) Limited

Scholars Mews Care Home

Inspection report

23-34 Scholars Lane
Stratford Upon Avon
Warwickshire
CV37 6HE

Tel: 01789297589
Website: www.averyhealthcare.co.uk/care-homes/warwickshire/stratford-upon-avon/scholars-mews/

Date of inspection visit:
17 October 2023
18 October 2023
19 October 2023
24 October 2023

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27 December 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Scholars Mews Care Home is a residential care home providing accommodation with personal care for up to 64 people. It is a purpose-built home in which care is provided across 3 floors. Residential care was being provided on the ground floor and dementia care was being provided on the first and second floor. At the time of our inspection visit there were 43 people living at the home. Some of these people were living with dementia, physical disabilities and mental health conditions.

People's experience of using this service and what we found
People were not safeguarded from abuse and avoidable harm because safeguarding systems were ineffective in keeping people safe. Staff did not always report allegations of abuse in a timely way. Staff did not always feel able to challenge unsafe or poor practice because their concerns were not always listened to or acted upon.

People's injuries were not always recorded or reported. Where injuries were reported, these had not always been investigated. This practice prevented the provider completing a thorough review to identify the cause of injury which increased the risk of improper treatment. The provider completed an analysis to identify patterns and trends of accidents within the home. However, this was not accurate because accidents and incidents were not always recorded and reported in line with the providers expectations. Where people had fallen, it was not always clear what action had been taken to reduce the risk of re-occurrence.

Staff did not always take action to mitigate any identified risks to people's health. Risk assessment tools did not always accurately reflect changes in people's health. There was limited information in care plans to ensure staff knew how to minimise risks to people's health and well-being.

The provider did not always ensure there were enough suitably skilled and competent staff on duty which compromised people's health and safety. Senior staff in particular had insufficient time to fulfil their duties. Staff competency was not always assessed to ensure staff had the right skills to deliver safe and effective care.

Medicines were not always managed safely. In each of the medication rooms we found large quantities of medicines that needed to be returned to the pharmacy. These were not stored in line with the providers policy or best practice guidance. Some people needed medicines on an 'as required' (PRN) basis to treat short term conditions such as pain or anxiety. Where medicines had been prescribed to help people manage levels of distress, it was not always clear when these medicines should be considered as guidance contained vague information. There was limited evidence to show a clear rationale for the administration of some PRN medicines.

There had been a period of managerial instability in the home. The provider and senior leaders failed to ensure the home had the right level of support, competency, and skill to provide people with safe, effective,

and compassionate care. The provider's systems and processes for monitoring the quality of the service were not effective. The serious and widespread issues found at this inspection had not been identified through internal quality monitoring audits and checks.

People were not always well supported or treated with respect and compassion. People's privacy was not always respected and promoted.

People were not always supported as individuals, or in line with their needs and preferences. There was a culture where staff encouraged people to stay in their bedrooms. Some people expressed distress through their behaviour. Records did not show this was always responded to consistently.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection
The last rating for this service was good (published 26 January 2018).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding, staffing numbers and risk management specifically related to falls. A decision was made for us to inspect and examine those risks.

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

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report. The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

Enforcement
We have identified breaches in relation to safeguarding, staffing, risk management, dignity and respect, person centred care and governance at this inspection.

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

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Scholars Mews Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
Four inspectors and an Expert by Experience completed this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. One of these inspectors made telephone calls to relatives to gain their feedback on the care provided.

Service and service type
Scholars Mews Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Scholars Mews Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was not a registered manager in post.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 17 October 2023 and ended on 24 October 2023. We visited the location on 17 18, 19 and 24 October 2023. Our visit on 18 October 2023 was during the night.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We sought feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information helps support our inspections We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people and 7 relatives about their experience of the care provided. We spent time with the people who lived at the home observing the quality of care and support they received. This helped us to understand the experiences of people who we were unable to communicate with us.

We spoke with 22 members of staff including the deputy manager who was managing the home at the time of our visit, 6 senior members of care staff, 10 members of care staff, the sous chef, 2 regional support managers, a regional director, and the operations director. We also spoke to a healthcare professional about their experience of the care provided.

We reviewed a range of records. This included information contained in 7 people's care records and multiple medicine records. We also looked at 2 staff recruitment files and records related to the overall management and quality assurance of the service.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

- People were not safeguarded from abuse and avoidable harm because safeguarding systems were ineffective in keeping people safe.
- The provider's safeguarding procedures were not always followed by staff. For example, staff did not always report allegations of abuse in a timely way which put people at potential risk of further harm.
- A serious safeguarding concern had been reported to the deputy manager but was not investigated. This meant a police and safeguarding referral had not been made in a timely way to enable external scrutiny.
- People's injuries were not always recorded or reported. Where injuries were reported, these had not always been investigated. This practice prevented the provider from completing a thorough review to identify the cause of injury which increased the risk of improper treatment.

Systems and processes were not operated effectively to protect service users from abuse and improper treatment. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- In response to our findings, the provider took some immediate actions to keep people safe. For example, a safeguarding referral was made to the police and local authority, all staff received a safeguarding themed supervision to ensure they understood the provider's safeguarding expectations and additional safeguarding training was scheduled.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

- Staff did not always take action to mitigate any identified risks. One person was at risk of falls and their risk management plan stated they should have crash mats next to their bed to mitigate the risk of injury. A crash mat was not in place throughout the first 3 days of our inspection despite assurance this would be actioned immediately.
- Two people were at risk of not eating and drinking well. Records informed staff to offer foods 'little and often'. Daily records did not evidence these people were regularly being offered food and fluids. For example, 1 person's records showed there were 2 days where there were no record of food or fluids being offered, and on other days there was only 1 nutritional intake record.
- Risk assessment tools did not always accurately reflect changes in people's health. For example, one person's skin integrity risk assessment did not reflect the person was no longer able to mobilise independently. This meant the level of risk was not correctly calculated.
- One person had a catheter. There was limited information to support staff in safely managing the catheter

and records of urine output were not consistently maintained. This meant risks associated with urine retention or infection may not be promptly identified.
● Where people had diabetes, there was no information in their care plans to indicate the signs of high or low blood sugar levels. The provider had a service level protocol for checking blood sugar levels if people became unwell, but there was not always a member of staff on duty who had received the appropriate training.
● The provider completed an analysis to identify patterns and trends of accidents within the home. However, this was not accurate because accidents and incidents were not always recorded and reported in line with the provider's expectations. For example, one person's records documented a slip and fall which were not on the falls log.
● Where people had fallen, it was not always clear what action had been taken to reduce the risk of re-occurrence.
● Medicines were not always stored or disposed of safely. Improvements were required to the safe storage of medicines. Some medicines needed to be stored below 25 degrees centigrade to ensure their effectiveness. Records did not always show the temperature of the medication room was checked to ensure medicines were stored at the correct temperature.
● In each of the medication rooms we found large quantities of medicines that needed to be returned to the pharmacy. These were not stored in line with the provider's policy or best practice guidance.
● Topical creams were not always applied in line with the prescribers' instructions.
● Some people needed medicines on an 'as required' (PRN) basis to treat short term conditions such as pain or anxiety. Where medicines had been prescribed to help people manage levels of distress, it was not always clear when these medicines should be considered as guidance contained vague information. This increased the risk of these medicines not being given by staff in a consistent and appropriate way.
● The provider could not evidence a clear rationale for the administration of some PRN medicines. Staff had not completed sufficiently detailed records to show these medicines were always given as a last resort. There was no evidence to show whether these medicines had been effective to enable a robust review by clinicians.

The provider had failed to assess the risks and do all that is reasonably practicable to mitigate risks associated with the health and safety of people using the service. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider took some action to ensure people were safe. For example, crash mats to protect people at high risk of falls were provided to people where this was an assessed need.
● PRN protocols were updated to ensure staff had enough information to give this medicine consistently and as prescribed.
● Immediate training was completed to ensure all senior staff knew how to identify, report and record accidents and injuries on the electronic system. This system then alerted the regional support managers to complete a thorough review of the accident to prevent reoccurrence.

Staffing and recruitment
● The provider did not always ensure there were enough suitably skilled and competent staff on duty which compromised people's health and safety. For example, over a 3-month period 46 falls were recorded in the home, of which 45 were unwitnessed by staff.
● The providers call bell analysis showed call bells were answered in a timely way. However, some people told us how they had to wait for staff to respond to requests for assistance. Comments included, "If I want to go to the toilet, I have to wait twenty minutes" and, "Staff do rush me when they are putting me to bed."
● Although the provider confirmed their assessed staffing levels had been maintained, a reoccurring

concern raised by staff was the number of staff on shift. Comments included, "Staffing is the biggest problem here. It is awful. We just cannot provide the care we want to people. People are left on their own and we have a lot of falls" and, "We are struggling in numbers. We don't know how to keep them [people] safe."

● A healthcare professional also raised concerns about safe staffing levels and told us, "When I walk onto the first floor, I see people trying to get up to mobilize and I am worried they will fall, and I am searching for carers but there is no one there."

● Senior staff in particular had insufficient time to fulfil their duties. They told us they were included in the staff numbers to provide direct care to people but had additional duties such as giving people their medicines, managing the care team, liaising with healthcare professionals , responding to accidents and incidents and completing care plan reviews. One senior staff member told us, "It is not physically possible to make sure everything is done well."

● Staff competency was not always assessed to ensure staff had the right skills to deliver safe and effective care. During our inspection we observed, and staff told us about specific times where they had witnessed poor care practices which compromised people's safety. One senior member of staff told us, "I don't have a break because I don't feel safe leaving the floor. I need to have my eyes everywhere."

The provider had failed to ensure staff deployment was sufficient in meeting people's needs and safety which placed people at increased risk of harm. This was a breach of Regulation 18 (Staffing) Regulated Activities) Regulations 2014.

● By the second day of our visit, the deployment of staff had been reviewed and changes were made to increase staff oversight on each floor both during the day and at night.

● Plans had been put in place to review staff competency and provide additional guidance and training to staff where this was needed.

● The recruitment process ensured staff were suitable for their roles by conducting relevant pre-employment checks. This included Disclosure and Barring Service (DBS) checks which provided information about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

Preventing and controlling infection

● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. Some crash mats and sensor mats in people's bedrooms were not clean. One person's pressure relieving cushion was split exposing the internal foam which was an infection control risk. Immediate action was taken to clean and exchange these items by the second day of our visit.

● Other areas of infection control practices were managed well. For example, the provider ensured people were admitted to the home safely, staff wore appropriate personal protective equipment and the staff knew how to manage an infectious outbreak safely.

Visiting in care homes

● Relatives and friends could visit whenever they wanted.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience
- The provider did not always ensure staff had the right skills, knowledge, and competency to deliver effective care and support.
- Staff reported examples where basic care principles had not been followed by some staff. One staff member told us, "I don't like the way some of the care workers care for people. I've seen staff lift people under their arms. I've told staff not to do this." Another staff member said, "Some of them [staff] don't even understand the basics and I keep having to tell them time and time again. Basics, like if you give someone a hot cup of tea, you don't serve it in a glass."
- Staff supervision and support was not consistently applied. Where staff had received supervision, this had not always improved staff competency.

The provider failed to ensure staff were suitably skilled and competent in meeting people's needs and preferences which placed people at increased risk of harm. This was a breach of Regulation 18 (Staffing) Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
- Prior to our visit, we had been informed of an incident at the home where staff had failed to seek timely medical advice for a person following a significant injury. This delay could have had serious implications for this person's health.
- One healthcare professional told us, "They are taking more and more complex patients and they can't manage their needs. Staff just didn't seem to know what to do and how to respond."
- Where people had declined to take their prescribed medicines, healthcare advice was not always sought to ensure people remained well.
- People's health needs were regularly reviewed by the GP who completed a weekly ward round at the home. However, it was not always clear if referrals to other healthcare professionals such as the mental health team or falls prevention team had been made in a timely way to improve outcomes for people.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- The provider completed an assessment before people moved into the home. However, we were not assured the admissions process was effective in ensuring staff had the necessary skills, experience, knowledge, and confidence to support people with complex needs arising from their mental health.

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Staff did not always seek people's consent before delivering care. One person told us, "They [staff] just do it. They don't ask my consent'.
- Mental capacity assessments had not always been completed when people's capacity to make a specific decision had been questioned. For example, one person was being given their medicines covertly. There was no evidence a mental capacity assessment or best interests' decision had been made about this important decision. The provider took immediate action to complete this by the second day of our visit.

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

- Daily records did not always evidence people were supported to eat and drink enough to maintain a balanced diet.
- We received some negative feedback about the food provided at the home. Comments included, "I don't like the food here" and, "I don't think much of the food but there's always sandwiches." Despite this, the food looked nutritious, and people were offered a choice of meals.
- Catering staff knew people's dietary needs. Each person's dietary requirements were recorded on a white board in the kitchen and detailed specific health requirements, allergies, and cultural needs. The sous chef told us any changes in people's needs were communicated by the care staff.

Adapting service, design, decoration to meet people's needs

- Improvements were required in the environment to meet people's needs, particularly those living on the first floor who were living with dementia. For example, there was little signage to support people to orientate themselves around the environment, there were limited dementia friendly house-hold items and limited use of contrasting colours to support people's needs.
- Where people wished to, they had personalised their own bedrooms and brought ornaments and photographs from home.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People were not always well supported and treated with respect. For example, during our visit we observed one staff member speaking about a person in a derogatory way whilst standing outside the person's bedroom. This staff member demonstrated a complete lack of understanding of the impact of the person's diagnosis on their emotional responses.
- People were not always treated with compassion. One staff member entered a person's bedroom and tried to wake them up using a demanding tone which was not consistent with high quality and compassionate care.
- One person's care record did not promote respectful and dignified care. Their care plan instructed staff to be 'firm' with the person during personal care and to show the person their soiled clothing or hands if they had been incontinent.
- People's privacy was not always respected and promoted. For example, staff walked into people's room's without knocking.
- Throughout our inspection, some staff shared various examples of where they had witnessed poor care practices with us. One staff member told us, "I was working with one staff member and after we had finished their night-time personal care the other carer said, 'don't you dare ring that bell in the night'." Another staff member told us they had observed a staff member providing personal care on urine-soaked sheets.

The provider had failed to ensure all staff treated people in a caring and compassionate way. This was a breach of regulation 10 (Dignity & Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some immediate actions were taken by the provider in response to these findings. For example, a staff member was suspended from duty, and the care plans that did not promote respectful and dignified care was amended.
- Despite these findings, there were some staff who did provide compassionate care to people. These staff had raised concerns about observed poor care practices by other staff and were dedicated to making the required improvements at the home.

Supporting people to express their views and be involved in making decisions about their care
- There was limited evidence to show how people were supported to express their views and make

decisions about the care they received.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not always supported as individuals, or in line with their needs and preferences. One person told us, "They [staff] don't sit and talk to me, they don't have enough time. I ask them to do something, and they say I'll be back in a minute, then they forget. I like a shower every other day, but they will say 'I'm running late, would you have a wash instead'."
- Records did not always show staff responded to people consistently when they expressed distress through their behaviour. For example, it was not always clear what preventative strategies had been tried.
- Planned activities did not always take place and staff did not always have time to spend meaningful time with people. One person told us, "It's not been great recently, the staff are too busy. We haven't been doing anything, like activities."
- One person's care record detailed how they enjoyed going to the cinema, dancing, doing puzzles and listening to music. During an 8-day period, records only showed this person had been encouraged to take part in 1 activity to enhance their emotional well-being.
- On the first day of our inspection staffing appeared very limited and most people were in their bedrooms. Two people were observed sitting at a dining room table in one area of the home. One of the people was clearly thirsty and kept trying to drink from their empty teacup. There was no staff presence in the communal dining room for at least 44 minutes which meant the person's need for support was not being responded to.
- There was a culture where staff encouraged people to stay in their bedrooms. One senior staff member told us, "I'm tired of telling staff to stop telling [person] to go back to their room. I tell them this is their home, if they wants to go to the lounge they can go." Another senior staff member told us, "The way some staff speak to people is not caring. You can hear them say things like 'go back to your room'. That is not how you promote good meaningful care. I tell them to actually do something meaningful with them."

The provider had failed to ensure people received person centred care which met their needs and preferences. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations
2014.

Improving care quality in response to complaints or concerns

- A complaints policy was in place, but this was not always actively promoted, and people were not always encouraged to give feedback on their experience of care.
- Some relatives told us they had raised concerns with the home; however, these had not always been

logged and there was limited evidence to show these had been investigated to improve care outcomes for people.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● People's communication needs were identified and recorded in their care plans. However, there was limited evidence to show how important information had been made accessible for people.

End of life care and support
● The home provided care to people at the end of their life. Records demonstrated people's preferences at the end of their life were sought.
● The deputy manager told us they liaised with the GP and district nurses to ensure all required medicines were in place, so people were comfortable and pain free in their final days.

Inadequate

Is the service well-led?

Our findings

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

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

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

- There had been a period of managerial instability in the home. The registered manager had left in July 2023. A new manager was then employed but left within a month and since this time, the deputy manager, with support from the regional support manager, had overseen the day to day running of the home.
- The provider had failed to ensure managers and senior staff had the right level of support, competency, and skill to provide people with safe, effective, and compassionate care.
- Staff with delegated tasks needed further training to ensure they had the skills to carry out those roles effectively. For example, one person with responsibility for carrying out risk assessments told us they had not had any specific training in that area.
- The provider's systems and processes for monitoring the quality of the service were not effective. The serious and widespread issues found at this inspection had not been identified through internal quality monitoring audits and checks. This put people at risk of harm due to ineffective oversight and governance.
- Multiple breaches of regulation were found in relation to safeguarding, risk management, staffing, dignity and respect, person-centred care and good governance.
- Systems to monitor people's health and wellbeing required more scrutiny. We saw important records were not always detailed enough to demonstrate people received the right levels of care and safe practices were followed. Some records contained conflicting information and risk assessment tools did not always accurately reflect when people's needs had changed.
- Monitoring of care records had failed to identify risks associated with people's care had not always been managed well
- The provider did not always plan, promote, or ensure people received person centred care which placed them at risk of receiving poor outcomes.
- During the inspection we were informed of 2 significant incidents that had not been reported to us, CQC, in line with the provider's regulatory responsibilities. These were submitted retrospectively.

The provider had failed to ensure systems and processes were operated effectively to ensure people received safe, effective and high-quality care. This was a breach of Regulation 17 (Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations
2014.

- A new registered manager had been recruited and was due to commence employment in December 2023.

Due to the seriousness of the concerns found during our inspection, the provider moved an experienced registered manager into the home to drive forward improvements.

● We contacted the Chief Executive Officer and Quality Director who acknowledged the serious shortfalls found during our inspection. They immediately put plans in place to address some of the immediate concerns we found. Following our inspection, they implemented an action plan with short timescales to improve standards and practices at the home, and ensure the safety of people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● We found no evidence to suggest duty of candour had not been followed for significant incidents in the home. However, improvements were required to ensure an environment was created where there was an open and honest culture.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Records did not show how people, relatives, staff or other healthcare professionals had been engaged with to improve care outcomes for people.

● Staff did not have regular opportunities to meet colleagues, or to discuss best practice in a learning and supportive environment. There were no regular team meetings.

● Staff did not always feel able to challenge unsafe or poor practice because their concerns were not always listened to or acted upon.

● There was a lack of engaging and involving people in decisions about their care.

Working in partnership with others

● At the time of this inspection visit, the provider and the management team were working with the local authority to a service improvement plan (SIP).