Beacon Place Limited

Maple Leaf Lodge Care Home

Inspection report

37 Beacon Lane
Grantham
Lincolnshire
NG31 9DN

Tel: 01476590674

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Maple Leaf Lodge Care Home is a residential care home providing accommodation for persons who require personal or nursing care to 52 people aged 65 and over at the time of the inspection. The service can support up to 67 people.

People's experience of using this service and what we found
Organisational governance and quality assurance arrangements had not been effective in monitoring and improving the quality and safety of the service. We found systemic failures with oversight and quality assurances posing significant risk to service users.

The provider demonstrated a variety of systems to monitor the quality of the service. However, the processes in place needed to be embedded and further developed to show the planned improvements could be sustained.

People did not always receive their prescribed medicines. Alternative methods of administration and contact with healthcare professionals had not taken place, which put people at increased risk of health deterioration.

There were significant shortfalls in Infection Prevention and Control and environmental safety processes. Areas of the home were unclean and unsafe. The provider had systems in place to record COVID-19 testing however, ineffective monitoring meant people were at risk of infection.

People did not always receive person centred care. Their needs and preferences could not always be met. End of Life care was not always dignified.

Staff were negative about their experience of working in the service. People and their relatives provided mixed feedback, raising concerns with communication and staffing, but also highlighted they felt their relative received good care.

The provider did not always follow or act in accordance with the Mental Capacity Act (MCA). There were delays in applying for Deprivations of Liberty authorisations, meaning people were at risk of being deprived of their liberty without the legal authority.

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.

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

Rating at last inspection and update:
The last rating for the service under the previous provider was good, published on 07 March 2020.

Why we inspected
The inspection was prompted in part due to concerns received about medicines management, infection control, staffing etc. 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 this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Maple Leaf Lodge Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, person centred care, Governance and Deprivation of Liberty at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

If the provider has not made enough improvement within this 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.

Maple Leaf Lodge 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 Care Act 2014.

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

Inspection team
The inspection was carried out by two Inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke to 23 relatives about their experience of the care provided. We spoke with 13 members of staff including the provider, registered manager, assistant manager, senior care workers, care workers and the chef.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● During our inspection we found the provider had failed to properly assess and mitigate a wide range of potential risks to people's safety and welfare, in areas including individual risk assessment, medicines management, infection prevention and control, safeguarding and organisational learning.

● People and staff were not protected from other people's behaviour which poses a risk of harm. For example, staff consistently told us they were not trained and did not know how to manage challenging behaviour. Records showed people had received injuries as a result of poorly managed behaviour and harm was caused to other people, staff and property damaged. Furthermore, there were no risk assessments in place in relation to the persons behaviour. Inadequate systems and processes failed to assess and manage behaviours placing people and staff at significant risk of harm.

● People were at risk as bedrails were not sufficiently assessed and risks were not mitigated. For example, we found a person's bed rails were only on one side of the bed, no bumpers and gaps between the bedrails and the head and foot board which exceeded dimensions specified by Health & Safety Executive (HSE) for safe use of bed rails. This posed a risk of entrapment and consequent injury.

● Records showed a high number of falls. Staff we spoke to told us they did not have the time or staff to reduce the number of incidents. One staff member told us, "When we go and do a double and there is only two of us, someone falls you don't know it's happened."

● People were not protected from the risk associated with weight loss. Several people were not being weighed and when weight loss was identified swift action was not taken to monitor this. For example, records showed a person had lost a significant amount of weight in a month. Although advice had been sought from the GP there was no care plan put in place in relation to the weight loss until a month later, and advice had not been followed.

Using medicines safely

● People did not always receive their prescribed medicines. We consistently found people not receiving their prescribed medicines for prolonged periods of time. There was no evidence to indicate alternative methods of administration had been considered. We also found no contact had been made with healthcare professionals to resolve this issue.

● For example, we examined Medicines Administration Records (MARs) and found medicines had not been administered 18 times over a period of 28 days due to the person sleeping. When we spoke to staff, they confirmed they routinely don't administer until the next dose. The failure to recognise and resolve issues with medicines administration put people at increased risk of not receiving their medicines as prescribed. This meant people's health needs were not effectively managed which placed them at increased risk of health deterioration.

● The provider failed to ensure the safety of people. Some people in the home became distressed.

Medicines prescribed supported the management of distress, however, people regularly didn't receive these medicines. This meant some people were at increased risk of escalated distress due to lack of medicines, placing them and other people at risk of harm.

Preventing and controlling infection

● Risks associated with staff contracting COVID-19 had not been identified and mitigated. A system was in place for staff to access testing. However, we found significant gaps in the testing matrix despite this being government guidance for care homes, the provider failed to ensure staff conducted regular weekly testing. This meant there was a risk staff who were asymptomatic, would not be identified in a timely way, meaning the provider failed to have a complete understanding of the COVID-19 status of the service, increasing risks to people's health.

● Several areas of the environment were unclean which posed a risk of infection and compromised the effectiveness of cleaning. Equipment in the kitchenettes was unclean and unfit for purpose. We found mouldy equipment and dirty furniture in the dining room. This dining room was frequently used by most people, and in an area which mainly accommodates people with dementia who are unable to ensure their own safety. This posed a significant risk of harm due to poor environmental safety and impacted on effectiveness of cleaning.

● We found Personal Protective Equipment (PPE) was not easily accessible for staff. Bathrooms and toilets on all three floors did not have items of PPE available for staff to use. We also found no clinical waste bins in bathrooms meaning staff could not dispose of their used PPE items safely and effectively.

● We reviewed cleaning schedules and identified on 18 June 2021 it was documented 'none done', we also identified gaps in scheduled cleaning duties, a staff member confirmed no cleaning took place that day or for the identified gaps, as they were redeployed to caring duties due to being short staffed. Infection Prevention and Control (IPC) risk were exacerbated by the ongoing risk from the Covid-19 pandemic, putting people at increased risk of infection due to a failure to ensure the cleanliness of the home.

Systems and processes to safeguard people from the risk of abuse

● Records showed staff had received safeguarding training and demonstrated an understanding of how to raise a safeguarding concern. However, when we spoke to staff they consistently told us the service was not safe and could not meet the needs of people. They had raised this with management and external professionals.

● Healthcare professionals had raised concerns in relation to people's safe care and treatment, we looked at documentation including staff meetings. However, this was not part of the agenda, meaning poor communication could limit improvements for the service. This demonstrated a failure to understand the importance of safeguarding vulnerable adults.

Learning lessons when things go wrong

● We found no evidence of organisational learning. At the time of the inspection the local authority had investigated three poor practice concerns relating to poor standards of care. The cases involved concerns relating to risk management, care planning, recording of information, poor communication and accessing healthcare services timely.

● The provider responded to the concerns raised, however, further incidents occurred and during the inspection we found significant risks in all the aforementioned areas. This demonstrated that the provider did not always learn lessons when things go wrong.

● The provider produced an action plan following the inspection to address the aforementioned areas. Immediate action was taken to address and mitigate risk. However, systems were either not in place, needed embedding or robust enough to address the concerns identified during the inspection. Due to systematic failures the provider failed to ensure the safety of people meaning they were at risk of harm.

The provider's failure to assess and manage a wide range of risks placed people at risk of avoidable harm and was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Records showed the provider had recruited staff and a number of background checks had been completed. These included checks with the Disclosure and Barring Service to show that the staff concerned did not have criminal convictions.

● During the inspection we reviewed arrangements for deploying staff. We found systems in place which indicated adequate staffing had been deployed. However, all staff we spoke to consistently told us they worked at low staffing levels directly impacting on the delivery of care.

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.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff told us new staff had been employed into the service but due to staff levels were not given the shadow shifts required. One staff member told us, "It was just me and her, there was no choice but to get stuck in, I didn't show her any care plans there wasn't time." Another new staff member confirmed they were part of the allocated deployment numbers for their first shift they were not an additional staff member on shift. The provider failed to adopt safe staffing practices, meaning staff had reduced opportunity to gain adequate skills and knowledge to meet the needs of people.
- We looked at the training matrix and despite showing staff had received training, systems were either not in place or robust enough to ensure staff were competent to meet the needs of people. Issues identified during inspection demonstrated staff lacked knowledge in regards of understanding dementia, falls management, behaviour management and medication management leading to people being at risk.
- Staff we spoke to consistently told us there had been no support from management. Staff also confirmed supervisions that took place consisted of a pre-prepared document which was handed to them to sign. Systems and processes in place failed to ensure staff had the ongoing support and competencies to meet the needs of people using the service, putting them at risk of avoidable harm.

Staff lacked competency and support in order to meet peoples' needs and assess and mitigate known risks to people. This was a breach of Regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People were at risk of being deprived of their liberty whilst receiving care without assessment and

authority. We requested information regarding DoLS authorisations from the provider. Records showed four peoples DoLS had elapsed by a significant period of time.
● When we spoke to the senior management, they confirmed systems had not been in place or effective to ensure DoLS were applied for in a timely manner, meaning people were deprived of their liberty without the legal authority.

Systems were either not in place or not robust enough to demonstrate people were deprived of their liberty with the lawful authority. This placed people at risk of harm. This was a breach of Regulation 13(5) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● As detailed in the Safe section of this report, we identified shortfalls in the provider's approach to managing the risk of weight loss. Staff we spoke to told us that hydration was also difficult to maintain and monitor as they did not have the adequate level of staff to meet this need. One staff member told us, "Hydration is a massive issue, we can't get them [people] to drink and due to low staffing, we don't have time to give drinks, we have a high number of UTI's [Urinary Tract Infections]." Another staff member told us, "It's hard work finding time to go and give drinks."
● More positively, some relatives told us, "The food is good, I used to have Sunday dinner with mum before COVID." Another relative told us, "I have not seen the food but [name of person] says he has enough food and choice."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● We spoke with healthcare professionals involved with the care of people. They told us management and staff lacked understanding and knowledge of how to support people with dementia. They expressed the support and staffing in place was ineffective, leading to escalation of distress quickly, posing risk to themselves and other people.
● The local authority had received three poor practice concerns in relation to the care and treatment of people, these had all been identified by healthcare professionals visiting the home.
● East Midlands Ambulance Service [EMAS] had also raised concerns in relation to conflicting information from staff, lack of communication and access to the building following an emergency call. This meant people were at risk of health deterioration and delay in necessary treatment. This matter was being investigated by the safeguarding authority. This matter was ongoing at the time of our inspection.

Adapting service, design, decoration to meet people's needs
● People were at risk of harm as the environment is not safe. We saw that damaged furniture was left in communal areas and people had access to areas of the home that posed a risk. The service accommodates people with dementia who may be unable to ensure their own safety, any attempt to use the furniture would potentially cause injury. This places people at risk of harm.
● People were at risk of deterioration of their emotional wellbeing. The environment was not dementia friendly; Healthcare professionals made daily visits and expressed the environment was not suitable or stimulating for people with dementia. It lacked access to open spaces and any form of stimulating environment.
● We reviewed an environment audit completed 15 June 2021, whilst it does identify the home is not dementia friendly it has not identified the environmental risk found during the inspection. This meant systems were either not in place or robust enough to identify risk of harm from environmental risk.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● The provider had highlighted they had ineffectively assessed people before moving into the service, meaning people had been admitted to the home when their needs could not be met. This posed a risk and directly impacted on them, other people and staff.

● For example, two recent admissions had complex needs which were not properly assessed meaning they presented a risk to themselves, others and staff.

● Records showed people's needs were not consistently assessed appropriately, directly impacting care delivery. As mentioned in the Safe section, care planning for risk management had been ineffective meaning people were at risk of avoidable harm.

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.

This is the first inspection for the new provider. This key question has been rated Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes and significant shortfalls.

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

- People did not consistently receive care and support that met their needs. This is supported by feedback from staff and people who told us the quality of care is poor and inconsistent. During the inspection we spoke to a person who appeared visibly upset, they told us, "This care home is terrible, I'm always waiting. I just want a wash, I try to do it myself, but I can't, they don't care."
- Staff told us they did not have enough time to meet people's needs, they have to prioritise meaning some people did not receive personal care. Another staff member also told us that getting to know the person is not an option due to staffing levels being so low and people were not stimulated, especially the ones isolated in their rooms.
- Staff consistently demonstrated derogative language and lack of respect to people, referring to people by the amount of staff they needed to help them. This involved using words like 'doubles' and 'singles'. Staff also referred to people as their room numbers. This was observed multiple times during the site inspection and when speaking to staff. This was further collaborated by relatives, one relative told us, "The staff are cruel and condescending, they just put her in front of a TV all day." Another relative told us, "Mum is always upset, the staff are unkind to her and mimic her accent."

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People did not consistently receive privacy and dignity during the delivery of care. This was further demonstrated from documents we reviewed during the inspection and feedback from staff.
- During the inspection we found agency staff asked to support people, however, no consideration had been taken if the female person would prefer male or female staff. We reviewed the persons care plan and no information had been added in terms of preferences.
- Records we looked at on inspection showed four agency staff and one regular staff working a night shift. Staff told us this happened a lot, and no information about people is given to agency staff. They also told us, "Some [people] don't like men going in, they have the right to choose it's all about dignity, but it can't always happen." Another staff member told us, "A lot of time is spent keeping people going into other peoples' rooms."
- Staff told us they were unable to provide dignified care, they were supporting a person with end of life care, but it was not dignified, "I couldn't even get to them every 30 minutes like we should, I couldn't give mouth care and repositioning due to low staffing, I apologised to the family."
- We received mixed feedback regarding relatives being involved with their loved one's care planning. One relative told us, "They do not review her care plan with me." Another relative told us, "They discuss his care

plan with me now and again." However, we did also receive positive feedback, one relative told us, "They ring up to discuss her care plans. They keep me well informed."

People were consistently treated with a lack of respect and dignity while they received care and treatment at the service. This was a breach of Regulation 10 Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for the new provider. This key question has been rated Inadequate. This meant the services were not planned or delivered in ways that met people's needs.

End of life care and support

- We reviewed documents regarding end of life wishes in place for people and found conflicting information. We found a respect form stating both life sustaining treatment to be administered and not administered. Conflicting information could lead to confusion and inappropriate care being given in the event of medical crisis.
- Issues had been highlighted in a safeguarding concern regarding end of life wishes of people. Due to staff not being aware or informing the emergency services of documented preferences regarding end of life wishes. This matter is being investigated by the safeguarding authority. This matter was ongoing at the time of our inspection. This meant peoples wishes were at risk of not being met and a dignified death not being supported. Systems were either not in place or robust enough to ensure peoples preferences and wishes for end of life could be met.

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

- Records showed care plans did not always contain the information to ensure people's needs and preferences could be met. For example, a person with complex dementia needs had a care plan, however, it did not contain sufficient guidance for staff about how to support them to ensure theirs and others safety.
- The current provider acquired the care home in January 2020, we found little work had been done to review and update care plans. This had been identified by the provider, however, the provider failed to take timely action to address the concerns putting people at risk.

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

- Staff consistently told us people where isolated and they didn't have time to support them. One staff member told us, "We get told off if we sit with residents, to get on with work." Another staff member told us, "They [people] don't get enough stimulation, we don't have the time. Staff feel so guilty, it's not ok."
- We had a mixed response from relatives, one relative told us, "Mum constantly rings me distressed. She is totally dependent on staff but is left, she has no social interaction."
- We found activity staff were employed by the provider and observed activities during the inspection. People appeared to engage and interact with the activities. However, we observed that other than some activities, there was not enough social stimulation for people.

The above concerns demonstrate a failure to ensure care and treatment is personalised specifically for the people using the service. 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

● The provider had a system in place to record complaints when they were received, and action taken. There were a policy and procedures in place for handling complaints. However, it was demonstrated this was not always effective.

● Staff consistently told us they did not feel listened to when they raised concerns. One staff member told us, "I told [name of manager] months ago this place was unsafe. I'm stunned it's a shock to them." Another staff member told us, "I can raise concerns, but they [management] don't listen to what carers have to say. It's been like that for about a year."

● We received mixed responses from relatives, one relative told us, "For improvement they need to listen and be more responsive to people." Another relative told us "We had issues with mums' room, and had to complain to get things done, she now has new carpets and curtains."

● This inconsistent approach to dealing with complaints means improving care quality cannot always be recognised or sustained.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Records showed the provider had assessed people's communication needs and how to meet these needs in their care plan. Care plans clearly set out what was their preferred communication method and the level of support needed and any equipment, for example hearing aids.

● We found the environment and staff deployment meant communication needs were not always effective. Signage identifying rooms was missing and not dementia friendly taken together with staff consistently telling us they did not have time to communicate with people. This meant communication needs, despite being assessed were not being met.

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.

This is the first inspection for the new provider. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The manager had failed to establish effective communication systems with staff, they consistently told us they felt demoralised and undervalued by management. One staff member told us "[Name of manager] said he will sack us all and run this place on agency, he basically said it was our fault all this happened."
- We spoke to more staff and received negative feedback regarding the manager and provider. They told us they felt unsupported. One staff member told us "We are at breaking point, we have no support from management, there's no staff and we are over worked." Another staff member told us "Morale is absolutely rock bottom, it's not a good place to work."
- When we spoke to relatives, we received mixed feedback, one relative told us, "I had to list all the things we [relatives] are not happy with, they are chaotic and don't care." Another relative we spoke to told us, "I think it's well run and organised."
- Poor internal communication resulted in poor outcomes for people. When we spoke to staff about people who had lost weight and not been weighed. The staff member told us "[Name of people] is 'bedbound' we cannot weigh them as we don't have hoist scales." When we addressed this with the management team, they told us that hoist scales were available. A breakdown in communication meant the provider failed to ensure risks were monitored effectively, posing a risk to people and health deterioration.

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

- Records showed a variety of systems to monitor the quality of the service. However, organisational governance and quality assurance arrangements had been ineffective in monitoring and improving the quality and safety of the service. This is evidenced by a failure to address actions regarding environmental safety, alongside a failure to address infection control concerns.
- Organisational governance and quality monitoring arrangements had been ineffective in assessing, monitoring and mitigating potential risks to people's safety, as evidenced by not identifying medicines administration issues and risk management. We found systems in place to monitor the safety and effectiveness of service provision, however, these were not operated effectively. The failure to ensure these audits were effective, significantly restricted your ability to identify risks and address shortfalls, exposing people to the risk of avoidable harm and poor-quality care.
- The medicines audits had not been effective. We found evidence medicines had consistently not been administered according to peoples prescribed instruction. This meant opportunities had been missed to proactively identify and address potential risks to peoples' safety and welfare.

● Audit documents we reviewed for environmental safety and infection control were also ineffective. Whilst the provider recognised the environment in regards of dementia friendliness needed to be improved, the environmental risk identified on inspection had not been recognised. Consequently, we found significant concerns in the aforementioned areas which posed risk to 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; Continuous learning and improving care

● The provider failed to sustain adequate management at the service, multiple changes to the management created additional risk and reduced their ability to identify, achieve and sustain Improvement. One staff member told us, "Nobody [staff] wants to be in the building." This meant there was a risk improvement plans would not be sustained in the long term.

● The provider had also failed to monitor the performance of the management team at the location. This was evidenced by the failings we found at the inspection not having been identified prior to our visit. This failure of organisational oversight and governance created additional risks to the safety and effectiveness of service provision.

● We discussed the areas of concerns within care delivery, governance and leadership with the provider. The provider responded to the concerns identified with an action plan, which gave us assurance the provider was committed to driving improvement in leadership and care delivery in the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Some relatives we spoke to told us communication with the manager was poor and needed to improve. Relatives also expressed concerns they were not informed when their family member had been unwell. One relative told us, "Communication is quite poor they never call back, mum was unwell and had injuries, but they never told us."

● Records showed a staff survey completed in September 2020; however, no actions were highlighted from the negative responses. For example, 40% of staff indicated they would leave if they had another job, and 34% would not recommend the provider. This meant the provider failed to make improvements following staff feedback.

● The provider needed to improve professional relationships with outside agencies to improve people's care. This was highlighted by the poor practice concerns submitted by healthcare professionals regarding the care and treatment of people. For example, due to a breakdown in communication, referrals had been completed by the healthcare professional due to the deterioration of the people which staff had failed to recognise.

Systems were either not in place or robust enough to assess and monitor the quality of the service. This placed people at risk of harm. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found a residents meeting had been held in May 2021 with seven people, this gave people the opportunity to express their views. Consequently a "You said, we did" poster was produced with actions. For example, people highlighted they would like exercise classes, the activity team have now planned an exercise class once a week.