



Care Quality Commission

Restgarth 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
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Effective	Inadequate
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Caring	Inadequate
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Responsive	Inadequate
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Well-led	Inadequate
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Overall Service Commentary

Date of inspection: 24 September 2025 and 1 October 2025

The service is a residential care home providing support for up to 32 older people some of whom may be living with dementia. This was the first inspection since the service had been registered with the provider.

There was no effective or consistent management at the service resulting in extremely poor oversight of people's care. There was no manager in post. Managers from the provider's 2 sister homes were supporting the service remotely but did not visit regularly. The deputy manager did not always have the time needed to carry out necessary managerial tasks such as reviewing care plans.

The provider had not established a good learning culture. Action taken when things went wrong did not mitigate the risk of recurrence. We identified examples of poor care which were repeated despite managers being aware of the shortfalls. Audits were not carried out to monitor the service.

Care plans and risk assessments were missing or had not been regularly reviewed to ensure they remained an accurate reflection of people's needs.

There were staff vacancies at the service and staff numbers were not always sufficient to meet people's needs. Staff were not recruited safely, lacked training and were not receiving support through regular supervision.

We identified breaches of regulations in relation to safe care and treatment, consent, dignity and respect, staffing, recruitment and management of the service.

This service has been rated inadequate and 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.

In instances where CQC has begun a process of regulatory action, we may publish this information on our website after any representations and/or appeals have been concluded, if the action has been taken forward.

We have asked the provider for an action plan in response to the concerns found at this assessment.

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Overall People's Experience

Whilst people and relatives were positive about the quality of care, this did not reflect the evidence we found during this assessment. There was lack of meaningful activity available and people were left for long periods with little to occupy them. People were not treated with dignity and respect. Call bell logs showed people did not always receive support when they needed it.

Most relatives felt the activities and overall level of stimulation for people needed improvement, particularly for those who stayed in their rooms.

However, relatives told us the service kept them updated about any changes in their family members' needs. They commented on the cleanliness of the service with one saying, "It always smells nice there, you don't really notice bad odours, it's clean, tidy and warm."

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Safe

Rating: Inadequate

Percentage Score: 38.00 %

► [How do we score this?](#)

Summary

This service is not safe

Commentary

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. This is the first assessment 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.

The service was in breach of regulations in relation to people's safe care and treatment, staffing, recruitment and management of the service.

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Safe

Learning culture

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not have a proactive and positive culture of safety based on openness and honesty. They did not listen to concerns about safety and did not investigate or report safety events. Lessons were not learnt to continually identify and embed good practice.

Prior to the inspection we had received information about one person being left for a long period of time without any support for continence care. This was not dignified and had put them at risk of developing skin damage. A manager had addressed the issue at the time, appropriately raised a safeguarding alert and discussed the importance of continence care with staff. Despite this we identified further incidents of this person, and others, being left for long periods of time with no support for continence care. This demonstrated opportunities to learn and improve practice had been missed.

External health care professionals had provided equipment for one person to minimise the risk of them developing skin damage. This had not been used as advised, staff reported this was because the equipment was faulty. However, records showed this was not correct, and the equipment had not been inflated correctly.

Following the inspection staff checked people's skin and identified 6 people with redness which, according to one of the supporting managers, appeared to be due to poor continence care. This demonstrated the failure to embed good practice when things had gone wrong had put people at risk of avoidable harm. We shared our concerns with the local authority.

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Safe

Safe systems, pathways and transitions

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not always work well with people and healthcare partners to establish and maintain safe systems of care. They did not always manage or monitor people's safety.

Systems to monitor people's safety were ineffective. Daily records highlighted when people had not received support in line with care plans. However, no-one had oversight of the records, and no action was taken in response.

Care plans were not up to date or complete. One person had been identified as being at risk of weight loss by a dietician in May 2025 and the care plan stated they should be provided with 3 balanced meals per day and offered regular snacks. Daily notes showed they had not eaten breakfast for 6 consecutive days between 19 September and 24 September 2025. On 18 September they had not eaten breakfast until 12:16 pm. On the 19, 20 and 21 September 2025 they had not had any lunch. There was no guidance for staff on how they might encourage the person to eat. There were no records to show regular snacks were offered. The care plan directed staff to weigh the person every month. This had not been done for the past 2 months.

However, people's needs were assessed before they came into the service. Assessments were completed by senior managers from the provider's sister homes.

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Safe

Safeguarding

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not work well with people and healthcare partners to understand what being safe meant to them and how to achieve that. They did not concentrate on improving people's lives or protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect.

People were not safeguarded from poor and inappropriate care and opportunities to improve people's experiences following safeguarding concerns were missed. A senior manager had raised a safeguarding concern when they had identified one person had been left without support for a long period of time. This incident had been discussed with the staff team and highlighted as an example of poor care. However, during the inspection we observed the person, and others, had again been left without support for extended periods. This demonstrated actions taken to minimise the risk of reoccurrence had been ineffective and meant people were exposed to ongoing risk of harm.

Training records showed one third of the staff team were not up to date with safeguarding training. Staff were not aware of the organisation's whistle-blowing policy. However, they were able to describe what they would do if they had any concerns.

When safeguarding concerns had been identified by managers these were reported to the local authority and CQC as required.

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Safe

Involving people to manage risks

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not work well with people to understand and manage risks. Staff did not provide care to meet people's needs that was safe, supportive and enabled people to do the things that mattered to them.

Risk assessments were not all up to date and did not provide staff with accurate information on how to keep people safe. One person's care plan highlighted 14 risk assessments as due for review.

Some people had risks associated with their behaviour which had not been documented or mitigated. For example, a manager told us one person sometimes took items from other people and would often pick up items of cutlery and walk around with them. This put the person and others at risk. There was no risk assessment in place. There was no guidance for staff on how they could mitigate the risk and help ensure people's safety.

Some people had air mattresses to mitigate the risk of skin damage. We checked the settings for 3 of these mattresses. One was set to accommodate a weight of 130kg. The person's last recorded weight was 95.7 kg. however, they had not been weighed since March 2025. The other two mattresses were of a different type and were set as medium. Staff did not have access to the manufacturer's manuals so they would not know what the setting should be.

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Safe

Safe environments

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

and communication needs with them.

Processes

The provider did not always detect and control potential risks in the care environment. They did not always make sure equipment, facilities and technology supported the delivery of safe care.

Personal Emergency Evacuation Plans (PEEPs) had been completed. However, information in many of them was either inaccurate or incomplete. Some of the PEEPs did not contain a room number to highlight where that person was. Others referred to people who were no longer using that particular room.

Water temperature checks were not being carried out. A member of staff told us this was because, since moving from a paper-based system to an electronic one, there was no system for recording the temperature. They told us it was not important as the water temperature was regulated by thermostatic mixing valves. However, regular safety testing should be completed to ensure the equipment remains effective and water temperatures are within the recommended range.

Other safety checks were completed. For example, fire extinguishers, hoists and a stair lift were regularly serviced. Fire drills were completed, and fire doors and emergency lighting were checked as required.

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Safe

Safe and effective staffing

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not make sure there were enough qualified, skilled and experienced staff. They did not always make sure staff received effective support, supervision and development. They did not work together well to provide safe care that met people's individual needs.

The service was short staffed, and a recruitment process was on-going. We analysed staff rotas for September 2025 and found staffing levels fluctuated significantly. For example, on Saturday 6 September there were only 4 staff working during the day whilst on Saturday 13 September there were 9 staff on duty. There had been no significant changes in the needs of people using the service between these dates. This indicated staff numbers were not always sufficient to meet people's needs.

Rotas showed some staff were working excessive hours. We identified one occasion when a member of staff had worked a waking night shift due to staff sickness. They had also worked through the day and so had completed a 24 hour shift. This meant they may not have been able to provide quality care.

There were only 2 members of staff working during the night. Six people were cared for in bed and all required support from 2 members of staff when receiving personal care. This meant staff might not be available to respond to people's needs quickly. Staff told us people's beds often needed changing in the mornings as they were wet. This indicated people were not effectively supported with continence care during the night. Following the inspection the provider told us they had increased staffing numbers, including at night.

Due to vacancies in the kitchen, care staff were covering shifts preparing meals. This included the deputy manager which impacted on their ability to oversee the service. This was significant as there was no manager in post. Managers from the provider's sister home were supporting the service but were not present on a daily basis.

There were gaps in staff training; 14 of the 28 members of staff employed had completed less than 75% of the required training. Two members of staff who were working in the kitchen, did not have in date Food Hygiene training. Following the inspection the provider told us they were arranging training updates for all staff.

Systems to ensure staff were suitable for work in the sector were not robust. One member of staff had received a negative reference. This had not been discussed at interview; there was no risk assessment to set out how the risk could be managed. Another member of staff had only provided references from past colleagues and not from a previous employer.

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Safe

Infection prevention and control

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not always assess or manage the risk of infection. They did not always detect and control the risk of it spreading.

The service employed housekeepers and laundry staff. Throughout the inspection we observed housekeeping staff were busy, cleaning schedules were completed daily and communal areas were clean and tidy. However, the kitchen was dirty, the floor was sticky underfoot and the areas beneath kitchen units had not been swept. There was no evidence of scheduled deep cleans of the area to ensure all parts of the kitchen were clean. A member of staff told us the kitchen had not been deep cleaned for 'about a year.'

We observed staff administering medicines. They did not wash their hands before and after giving medicine which put people at risk of infection.

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Safe

Medicines optimisation

Overall Score

1 2 3 4

► How do we score this?

Summary

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

Processes

The provider did not always make sure that medicines and treatments were safe and met people's needs, capacities and preferences. Staff did not always involve people in planning.

Medicines must be stored within specific temperature ranges to maintain their safety and effectiveness. Temperature records showed that readings taken throughout September had exceeded 25°C on 27 occasions. The senior manager told us they were aware of this issue, and the medication room was not "fit for purpose". However, no actions had been taken to minimise this immediate risk to ensure medication was stored safely.

Some people were prescribed medicines to be taken 'as needed' (PRN). Information to direct staff on when and how these medications should be given and any associated side effects (protocols) were not available to staff. We asked a senior manager for the PRN protocols and the information received had not been reviewed recently and was not available to staff.

The care plan for one person listed their medications, however this differed from the information on the electronic medication administration record. This meant the care plan was not up to date, and staff were not provided with accurate information.

Staff received training in the administration of medicines, the provider's medication policy stated each staff member responsible for administering medication should complete an annual competency observation. We reviewed the staff files and found this had not been completed. The provider had not ensured staff were able to administer medication safely.

During our inspection we observed staff administer medicines which required stricter controls. These are known as Controlled Drugs (CD's). Staff were seen to sign the CD register before administering the medicine. This was not in line with best practice guidance or the organisation's policies and procedures which clearly stated staff should sign after the medicine was given.

Effective

Rating: Inadequate

Percentage Score: 33.00 %

► [How do we score this?](#)

Summary

This service is not effective

Commentary

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 assessment 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.

The service was in breach of regulations in relation to safe care and treatment, consent and management of the service.

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Effective

Assessing needs

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not make sure people's care and treatment was effective because they did not check and discuss people's health, care, wellbeing and communication needs with them.

People's care plans were not all up to date and some had not been reviewed for several months. We identified inaccuracies in some care plans. For example, a relative told us their family member needed support at mealtimes. The person's care plan stated, '[Name] does sometimes need prompting with fluid intake but can drink and eat independently.' A supporting manager told us they had recently carried out an audit of care plans and were aware they required updating.

When care plans had been reviewed this had not always been done in consultation with people or their relatives.

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Effective

Delivering evidence-based care and treatment

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not plan and deliver people's care and treatment with them. They did not follow legislation and current evidence-based good practice and standards.

One person had lived at Restgarth since August 2025. No care plans had been developed detailing their specific needs. There was no guidance for staff to help ensure they had the information they needed to support the person in line with current standards and best practice.

Some people required additional monitoring or support with continence care to protect them from identified risk. This had not been consistently provided. For example, people's nutrition and hydration needs were monitored and the electronic care system flagged when people had not had sufficient to drink and/or eat. However, this was not being actioned putting people at risk. For example, one person's recommended fluid intake in a 24-hour period was 1500 ml. Daily records showed they had only consumed 220 ml over the past 24 hours. No action had been taken to address this.

We identified one person who had not been supported with continence care for several hours. However, the care records indicated they had received support. A manager told us this was due to an anomaly in the recording system. Although they were aware of this no action had been taken to address the issue to ensure records accurately detailed the support people had received.

Some people were living with dementia; the design and layout of the premises did not take their needs into account. For example, there was no signage in the building, this can maximise independence and provide clear orientation and personalisation for both residents and staff.

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Effective

How staff, teams and services work together

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not always work well across teams and services to support people. They did not always share their assessment of people's needs when people moved between different services.

We received mixed views from professionals about how the service worked with them. For example, one healthcare professional told us, 'Management are approachable and receptive to feedback, responding promptly to queries or concerns.' However, another described the service as 'absolute chaos.'

Staff attended handovers between shift changes. This did include some key information about people's needs and any concerns about people's well-being.

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Effective

Supporting people to live healthier lives

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not support people to manage their health and wellbeing, so people could not maximise their independence, choice and control. Staff did not support people to live healthier lives, or where possible, reduce their future needs for care and support.

People were not supported to take part in meaningful activities which can support their physical and mental health and well-being. Although an activities co-ordinator was employed 3 days a week they were sometimes required to support other areas of the service. Relatives also told us the provision of activities had dropped and a member of staff commented, "There are zero

activities except nail care, no stimulation. People don't go outside because there are not enough staff." Staffing issues had also restricted people's opportunities to use the garden during the summer months. A relative commented, "It used to be used a lot. I think I've only seen people out there once this year."

Staff had not always received, or refreshed, training for supporting people with specific needs. For example, only 6 members of staff had up to date training in oral health care, no staff had received training for supporting people with mental health conditions and only 8 members of staff had up to date training for supporting people when they were distressed or anxious. This meant staff might not have the skills and knowledge to support people to manage their health and well-being.

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Effective

Monitoring and improving outcomes

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not routinely monitor people's care and treatment to continuously improve it. They did not ensure that outcomes were positive and consistent, or that they met both clinical expectations and the expectations of people themselves.

Processes for monitoring people's health were not consistently followed. For example, there was no evidence of learning following untoward events. Systems for the monitoring of people's skin integrity and food and fluid intake was not effective.

Where staff had identified concerns in relation to people's wellbeing no action had been taken to meet their needs. For example, staff had recorded physical observations for one person which identified their temperature was low, blood pressure high and they were hallucinating. No further action was taken in response to these negative indicators to ensure the person's safety.

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Effective

Consent to care and treatment

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not always tell people about their rights around consent and did not always respect their rights when delivering care and treatment.

The provider was not consistently working within the principles of the Mental Capacity Act 2005 (MCA). Mental capacity assessments had not always been completed appropriately. We identified one person where a decision had been made on their behalf which potentially infringed their human rights. There was no evidence the decision had been taken in the person's best interest.

However, we heard staff asking for people's consent before providing care. We heard a member of staff ask one person, "What would you like to happen today." They went on to ask if they could carry out a personal care task and explained why this was important.

Caring

Rating: Inadequate

Percentage Score: 35.00 %

► [How do we score this?](#)

Summary

This service is not caring

Commentary

Caring – this means we looked for evidence that the provider involved people and treated them with compassion, kindness, dignity and respect. This is the first assessment for this newly registered service. This key question has been rated inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

The service was in breach of regulations in relation to people's safe care and treatment and dignity and respect.

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Caring

Kindness, compassion and dignity

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

People's Experience

The provider did not always treat people with kindness, empathy and compassion, or respect their privacy and dignity.

People's dignity was not always respected. During the assessment we observed people were not assisted with continence care. One relative told us they were worried about visiting their loved one as they had previously found them in need of personal care and distressed due to staff not completing regular checks.

Another relative described finding their family member sitting on the side of the bed, half undressed with a used continence pad left on top of personal photographs. They told us, "This isn't care."

We observed several rooms where people were asleep in bed with the door open. We discussed this with a manager who told us some people asked for their door to be left open. This was not recorded in care records, and we could not be assured people were happy with the arrangement.

Records showed people were infrequently supported to bathe or shower.

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Caring

Treating people as individuals

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

People's Experience

The provider did not treat people as individuals or make sure people's care, support and treatment met people's needs and preferences. They did not take account of people's strengths, abilities, aspirations, culture and unique

backgrounds and protected characteristics.

A supporting manager told us care plans had not been reviewed, and some had not been completed in full. Staff told us they were not aware of one person's medical diagnosis and therefore were not aware of the person's needs.

One member of staff had received an injury to their arm from a person who was distressed. We reviewed the care plan for this person and found no guidance for staff on the actions they should take to respond to this behaviour. This lack of clear guidance meant there was a risk of inconsistent care which could cause further distress for the person.

One person was prescribed a medication that contained an animal product, and staff were observed administering the medication to the person. The person told us they were a vegetarian. Staff were not aware of the medication ingredients, and the care plan did not evidence if the person was aware and had made an informed decision to take it

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Caring

Independence, choice and control

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not always promote people's independence, so people did not always know their rights and have choice and control over their own care, treatment and wellbeing.

People were not always supported in a way that promoted their wellbeing. We observed people sitting for long periods with little interaction from staff. A relative commented, "I don't get a feeling of happiness, there's not much laughter." Staff told us they were often too busy to spend time engaging with people or offering activities.

One person told us they were bored. When we revisited them later, we noted they had moved the position of their chair. They commented, "Yes, I thought I'd see what it felt like facing this way." A relative commented, "Because [relative] stays in bed they don't get much stimulation."

Some people living at the service had a diagnosis of dementia. There was no signage to support orientation or promote independence. Bedroom doors were not clearly marked or individualised so people could easily recognise them as being their room. During the inspection one person appeared confused, and we assisted the person to find their room.

However, during the inspection we observed family visitors were able to visit their loved one throughout the day. Relatives comments included; "They encourage [pronoun] to get up" and "[Relative] likes to walk up and down the corridors, the staff like them and stop to ask how many steps they've done today, they have a nice rapport with them" and "The carers know [pronoun] likes music and put the radio on which [pronoun] likes in the background."

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Caring

Responding to people's immediate needs

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not listen to or understand people's needs, views and wishes. Staff did not respond to people's needs in the moment or act to minimise any discomfort, concern or distress.

People did not always receive care when they needed it. Daily records and our observations identified people who did not receive care for long periods during the day. For example, on the first day of the inspection we noted 2 people who appeared not to have received support throughout the day. We asked managers to review the CCTV footage for the day and the previous day to check if they had received appropriate support. The records showed, on 23 September 2025, one person was taken to the dining room for breakfast at 7.37 where they remained until after lunch. At 14.06 they were taken to a shared lounge and then back to the dining room at 16.31. At 18.31 they were taken back to their room. They were not assisted with continence care or repositioning during these times, a period of just under 13 hours.

Staff and some relatives told us call bells were not answered quickly. We reviewed the call bell log. Some calls were answered within seconds, but others took much longer. In one case, a person waited up to 39 minutes for support. We received feedback from a professional who reported an occasion when a member of staff stated they did not have time to assist the person. This meant people's care needs were not always met in a timely or respectful way. Relative's comments included; "Theres not always enough staff there. Once we rang the doorbell and had to wait 10 minutes before being let in. We went up to her room and [relative] was in bed with the call bell ringing. I think they do their best though" and "The girls working there seem good at their job, but we heard call bells ringing."

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Caring

Workforce wellbeing and enablement

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

and communication needs with them.

Processes

The provider did not always care about and promote the wellbeing of their staff. They did not always support or enable staff to deliver person-centred care.

The provider failed to ensure staff received appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out their role and support their wellbeing.

Staff spoke positively about the deputy manager but felt they were not well supported on a day-to-day basis. Supervisions were not taking place regularly, although managers from the organisation's sister homes were providing some managerial support this was mainly remotely.

Staff spoke openly of a divide within the team. Some staff indicated this was linked to religious and cultural differences. The staff meeting minutes highlighted this was an issue a month before our inspection, however staff told us this had not been rectified.

Multiple staff told us they felt unable to raise concerns, as when they had raised concerns previously these were dismissed or ignored by the senior leadership team. Staff were seen to be visibly upset and worried about the lack of care provided to people.

Responsive

Rating: Inadequate

Percentage Score: 29.00 %

► [How do we score this?](#)

Summary

This service is not responsive

Commentary

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

This is the first assessment for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

The service was in breach of legal regulation in relation to safe care and treatment and dignity and respect.

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Responsive

Person-centred Care

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not make sure people were at the centre of their care and treatment choices and they did not always work in partnership with people, to decide how to respond to any relevant changes in people's needs.

People's care plans were inaccurate and had not been regularly reviewed and updated. People and relatives were not all aware of care plans. There was some information about people's backgrounds and what mattered to them, but this was limited. Care plans had not been updated to ensure they reflected people's needs accurately.

However, relatives told us staff knew people well. Comments included; "[Member of staff] also talked to us about what [relative] most liked to eat, which is eggs. Sometimes [member of staff] would have some eggs cooked especially" and "We have talked to the staff about mum's life and interests, it's important that they know about the people they look after."

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Responsive

Care provision, Integration and continuity

Overall Score

1 2 3 4

[▶ How do we score this?](#)

Summary

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

Processes

There were some shortfalls in how the provider understood the diverse health and care needs of people and their local communities, so care was not always joined-up, flexible or supportive of choice and continuity.

Staff told us people were not being supported to access the community as often as they had been in the past. Relatives also commented on this change.

Healthcare professionals visited the service to provide care and guidance. This included GP's, district nurses and dentists. Feedback from professionals was varied, comments included; "There appears little leadership when I visit. Senior carers appear to have variable knowledge. A couple of times when I visited I asked carers to stay but they kept wandering off; I had to be quite blunt to request them to stay" and "I've made suggestionswith a senior manager or deputy if needed when they are away to maintain consistency and have someone who knows what's going on with people but this has been ignored." This reflected the lack of oversight in the service.

However, other professionals commented; "Management are approachable and receptive to feedback, responding promptly to queries or concerns" and "Residents seem happy and relaxed, and the staff are knowledgeable about their needs."

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Responsive

Providing Information

Overall Score

1 2 3 4

[▶ How do we score this?](#)

Summary

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

Processes

The provider did not supply appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

Some people had care plans relating to their communication needs. For example, whether they used hearing aids or needed glasses for reading. However, the information was not always accurate. One person's care plan stated they were able to communicate verbally. A senior manager and a relative told us the person's communication was poor.

The menu was written on a blackboard mounted on the wall. This was not accessible to everyone living at Restgarth. There were no alternative formats available. Staff had not completed training for the Accessible Information Standard and not all staff had up to date training in communication skills.

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Responsive

Listening to and involving people

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not make it easy for people to share feedback and ideas, or raise complaints about their care, treatment and support. Staff did not always involve people in decisions about their care or tell them what had changed as a result.

People and their relatives were not routinely asked to feedback about their experiences. Resident and relative meetings had not been arranged.

Relatives told us they knew how to complain. Feedback about how the service responded to complaints was varied. One relative told us managers had listened to their concerns and responded openly, taking action to address the concerns. However, we found the actions taken had not been effective. Another relative told us of an occasion when they wanted to raise an issue but said, "There are no managers about to raise it with." When they had made a complaint, they told us nothing had been done to prevent the problem recurring.

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Responsive

Equity in access

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not make sure that people could access the care, support and treatment they needed when they needed it.

Some people were cared for in bed and were particularly reliant on staff to meet their needs at all times. Call bell logs showed staff did not always respond to requests for support in a timely manner.

People had access to other health professionals such as district nurses, chiropodists and dieticians. There was a GP linked to the service who carried out weekly consultations. However, we found one person had been identified as needing a Speech and Language Therapy (SALT) referral in May 2025. This had not been completed.

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Responsive

Equity in experiences and outcomes

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

Staff and leaders did not actively listen to information about people who are most likely to experience inequality in experience or outcomes. This meant people's care was not always tailored in response to this.

The provider failed to recognise the inequalities people may face. These inequalities and people's needs were not always considered. People were not supported to access their community. Reasonable adjustments had not been made to the environment to enhance the independence of people living with

dementia. The activities provided were limited and not designed for people living with dementia or for people who were cared for in bed. This meant action had not been taken or considered to address and remove barriers ensuring people had equal opportunities to live a full and varied life.

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Responsive

Planning for the future

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

People were not supported to plan for important life changes, so they could have enough time to make informed decisions about their future, including at the end of their life.

People did not have end of life care plans. Any information about people's wishes at this time of their lives was limited to their wishes to not be resuscitated or treated in hospital.

Well-led

Rating: Inadequate

Percentage Score: 32.00 %

► [How do we score this?](#)

Summary

This service is not well-led

Commentary

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 assessment for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

The service was in breach of legal regulation in relation to management of the service.

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Well-led

Shared direction and culture

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not have a clear shared vision, strategy and culture which was based on transparency, equity, equality and human rights, diversity and inclusion, and engagement. They did not always understand the challenges and the needs of people and their communities.

Due to the inconsistent oversight there was not a clear vision or culture within the service. Staff told us they were 'constantly firefighting.' There were limited opportunities for managers to share organisational values with staff. Staff had not had supervision sessions where they could discuss any issues or gaps in training. Staff meetings had been held in response to safeguarding concerns, but these had been infrequent.

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Well-led

Capable, compassionate and inclusive leaders

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not have inclusive leaders at all levels who understood the context in which they delivered care, treatment and support, or who embodied the culture and values of their workforce and organisation.

There was no manager at the service. Managers from 2 of the organisation's sister homes had been providing support but this was largely remotely. One manager visited the service monthly. A deputy manager was employed. However, records showed they were sometimes required to cover staffing gaps, providing care or working in the kitchen, and did not always have the time to complete managerial tasks such as updating care plans.

Professionals told us staff lacked guidance, and staff told us morale was low. There had been a high turnover of staff, and one manager told us some new staff had left very quickly after starting work. They were trying to address this

by improving systems for support during induction. However, we saw one new member of staff was working without completing any shadowing shifts. This meant they had not had an opportunity to build their confidence and observe more experienced staff.

Following the inspection the provider recruited an interim manager to oversee the service and work to make the necessary improvements. They were also actively looking to recruit a new registered manager.

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Well-led

Freedom to speak up

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

People did not feel they could speak up and that their voice would be heard.

Staff told us morale was low in the team, and one told us they were 'at breaking point.' Staff told us they had spoken with leaders about people's needs not being met but did not feel this was acted on. Comments included, "[Name] doesn't seem to understand how bad things are" and "We are told things will improve, lots of promises, but it doesn't change."

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Well-led

Workforce equality, diversity and inclusion

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider had not ensured an inclusive and fair culture by improving equality and equity for people who worked for them.

Some staff told us they did not feel valued. One member of staff described how they had stayed on to support the service when they were short staffed. They commented, "I've got more responsibilities than before."

However, other staff told us they were well supported. Staff from overseas were provided with accommodation. One said they often worked additional hours but this was their choice and there was no pressure for them to work overtime.

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Well-led

Governance, management and sustainability

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not have clear responsibilities, roles, systems of accountability and good governance. They did not act on the best information about risk, performance and outcomes, or share this securely with others when appropriate.

The provider's governance systems and management arrangements were ineffective. Audits and checks were not being completed to monitor the service. Accidents and incidents were recorded individually but there was no system for analysing them to help identify any themes or trends. A medication audit had been completed 2 months prior to the inspection but this could not be located. An audit of care plans had recently been completed which identified multiple gaps in the records. However, work to address this had not started.

Monitoring systems and processes were not effectively or consistently followed. Prior to the inspection a manager had identified people were left without welfare checks for significant periods. On both days of the inspection visits we again identified several individuals who were at risk due to a lack of support. Action taken to address the issue had not resulted in improving people's experiences.

People were not being weighed regularly, including people identified as being at risk due to poor nutrition. Some people had not been weighed since March 2025, including 1 person who had a pressure mattress which required setting in line with the person's weight. This failing had not been identified by managers prior to the inspection.

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Well-led

Partnerships and communities

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not always understand their duty to collaborate and work in partnership, so services worked seamlessly for people. They did not always share information and learning with partners or collaborate for improvement.

Following the inspection site visits and in response to the level of risk people were exposed to, partner agencies started working with the service to drive improvements. Feedback from partners supporting the service in the days immediately following the inspection to ensure people's safety was that progress was slow. Although issues were highlighted there was a pattern of problems recurring indicating actions to address issues were ineffective.

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Well-led

Learning, improvement and innovation

Overall Score

1 2 3 4

► [How do we score this?](#)

Summary

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

Processes

The provider did not focus on continuous learning, innovation and improvement across the organisation and local system. They did not encourage creative ways of delivering equality of experience, outcome and quality of life for

people. They did not actively contribute to safe, effective practice and research.

As stated throughout the report we identified, before, during and after the inspection, a theme of poor care practices being highlighted to senior staff, this being acknowledged and reassurances given, but the poor practices being repeated. For example, people were repeatedly left for unacceptably long periods without personal care checks or any meaningful interaction or engagement.

People's needs associated with their dementia were not taken into account. The environment was not set up to meet these needs.