

London and Manchester Healthcare (Fulwood) Limited

Hulton House Care Residence

Inspection report

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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

Hulton House Care Residence is a dementia specialist care home providing personal and nursing care to 66 people at the time of the inspection. The service can support up to 74 people across four separate units, each unit has separate adapted facilities. Two of the units specialise in providing care to people living with complex dementia nursing needs.

People's experience of using this service and what we found

People were at risk of avoidable harm because they were not always supported by staff with the skills or experience to keep them safe. We found examples of people causing actual harm to themselves and others. This had not been adequately managed or escalated in line with safeguarding and duty of candour processes. There was a closed culture which meant staff did not always feel able to raise their concerns. During the inspection staff disclosed serious allegations of people being exposed to abuse and improper treatment which we ensured were reported to the local safeguarding authority and investigated. The provider acted on our concerns and worked with external health and social care professionals to ensure improvements were made and they provided a safe environment for staff to disclose their experiences and concerns.

The registered manager failed to consistently deploy staff with sufficient training and experience to administer people's medicines in a safe way. We observed and untrained care staff confirmed, they were asked to administer people's medicines by staff deployed to undertake this task, this meant people were exposed to the risk of serious harm. People were not always protected from this risk of transmitting Covid-19 and other infectious disease because we found a number of staff failed to comply with the use of personal protective clothing and the processes to manage infection control were not robust.

There was a significantly high number of unreported accidents and incidents. There was evidence of electronic records being voided on the system which meant processes to identify trends, themes and incident levels in the service were ineffective.

People's needs and choices were not always assessed to ensure their care, treatment and support was delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes. There were significant shortfalls in the assessment of people's mental health needs and management of behaviours that challenge. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support best practice. Some staff told us about their participation in unplanned control and restraint techniques and we also observed this during the inspection.

People were not always treated with kindness, respect and compassion. There was a systemic culture where some staff did not have the skills or compassion to effectively engage and support people living with

dementia. We found examples of people's wellbeing being significantly impacted on negatively because staff did not always support them in a caring way.

We received mixed feedback from people's representatives, some told us they were very happy with the support people received others told us they were concerned about their relative's safety and the competency of staff supporting them. People were not always supported to express their views and be actively involved in making decisions about their care, support and treatment. People's independence was not always promoted.

The service was not well-led. There was a systemic closed culture which had not been identified by the organisation, this meant staff did not consistently feel able to raise their concerns. Some staff told us they felt bullied and told not to raise their concerns. The senior leaders within the organisation were not aware of the level of risk at the service and the registered manager had not internally escalated a number of incidents including safeguarding alerts.

Throughout the Covid-19 pandemic the senior management team had visited the service less frequently to reduce the increased risk of transmission however, this meant staff had less opportunities to share their concerns at a higher level. Staff told us the registered manager told them not to escalate their concerns outside of the home, or with senior leaders. During the inspection senior leaders took effective steps to encourage staff to feel confident to whistle-blow by means of anonymous surveys, staff surgeries, meetings and one to one supervision.

People's concerns and complaints were listened to. We found people and their representatives were satisfied with the way senior management responded to their concerns.

People did not always receive personalised care that was responsive to their needs.

People had access to meaningful activities when they were scheduled. Some people told us they would like to engage more in life skills, routine life activities to maintain their independence and this was restricted to scheduled times rather than being part of their daily routine.

The environment was fit for purpose and there had been substantial consideration around the adaptation, design and decoration of the premises for people living with dementia. People on all units could access outdoor areas and had plenty of communal space to walk with purpose.

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

Rating at last inspection

This service was registered with us on 22 August 2019 and this is the first inspection.

Why we inspected

The inspection was prompted in part due to concerns received about the care people received, infection control, staffing and a closed culture. 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 coronavirus and other infection outbreaks effectively.

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, medicines management, safeguarding, person-centred care, staffing and governance at this inspection.

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

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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.

Hulton House Care Residence

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 team comprised of five inspectors, one medicines specialist and two Experts 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. Only three members of the inspection team visited the service during the inspection and others reviewed evidence at desk top, this was to be mindful of the risk of people entering the service during the pandemic.

Service and service type

Hulton House Care Residence 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. There was a nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since registration. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

The inspection was undertaken across a two-week period. We spent two days onsite and the rest of the time was spent collating and analysing evidence at desk top. We spoke with six people who used the service and 21 relatives about their experience of the care provided. We spoke with 31 members of staff including the nominated individual, operations manager, registered manager, deputy manager, senior care workers, care workers, activity co-ordinator and a domestic worker. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at multiple staff files in relation to recruitment, training and supervision. A variety of records relating to the management of the service, including quality assurance audits were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We spoke with a range of professionals who regularly visit the service and participated in multi-disciplinary meetings with the local authority and health commissioners to discuss the level of risk at the service and gain assurances from commissioners about their oversight of the service.

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.

Systems and processes to safeguard people from the risk of abuse

- There was a closed culture and failure to safeguard incidents which exposed people to harm and improper treatment. For example, we found evidence people had been physically restrained by staff without the essential skills to do so in a safe and ethical way. People's care plans did not provide clear person-centred information to direct staff how best to support them when they were distressed or anxious to ensure the least restrictive options of support were provided.

- The registered manager failed to ensure people were protected from this abuse.

They had failed to share information with members of the senior management team about a number of safeguarding and whistle-blowing incidents made direct to them by the local safeguarding authority. This meant overarching safeguarding assurance systems were ineffective. Staff told us they did not feel confident or able to raise their concerns for fear of retribution.

- Staff at all grades did not always identify and report service user on service user abuse. For example, one person had assaulted other service users on a number of occasions and staff had not acted on this or raised an alert with the local safeguarding authority.

People had been exposed to harm and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager resigned on the first day of the inspection. The provider responded immediately and deployed senior managers from the organisation who met with all staff and offered a range of confidential ways for them to disclose any concerns or reportable incidents. We spoke with staff during this process and they assured us they felt able to speak openly to the senior management team.

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

- People were at risk of avoidable harm because they were not always supported by staff with the skills or experience to keep them safe. We found examples of people causing actual harm to themselves and others and this had not been adequately managed. For example, one person had a fall in the communal area and sustained injuries, their care plan and risk assessments were not adequately updated to show how the risk of further falls would be mitigated.

- Care workers recorded incidents such as behaviours that challenge and falls on the electronic care planning system. We found evidence that the electronic care planning system had been voided by the registered manager which meant the quality assurance processes for reviewing accident and incidents at provider/senior manager level was not triggered, subsequently failing to ensure risk in the service was effectively managed. We discussed this with the nominated individual who assured us the electronic system would be immediately reviewed to ensure this cannot happen again.

- Care workers did not receive handover before being deployed to support people with complex and unpredictable needs. Staff told us they had very little knowledge about the needs of people they supported. This meant people were at risk of being supported in an unsafe safe.

The above failings placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during the inspection and commenced reassessment of all service user needs with involvement from external health care professionals, for example the community mental health team. Care plan and risk assessments were being rewritten to ensure staff had access to accurate information and staff training was arranged including how to support people with distressed behaviours.

Staffing and recruitment

- The provider did not ensure there were sufficient numbers of suitably qualified, competent and skilled staff deployed. For example, at night time only one registered nurse was deployed to 50 people with complex needs. Staff told us they were unable to fulfil their role and responsibilities, and when they raised concerns with the registered manager they were ignored.
- The provider did not always ensure staff were of good character or had the necessary training and skills to support people in a safe way.
- The allocation of staff was not well coordinated. Agency workers were deployed to support people on one to one supervision without necessary training or awareness of the person's needs and preferences. We observed four agency workers undertake an unsafe intervention with one person which included the use of physical restraint, this placed the person at serious risk of harm and caused them to feel highly distressed. We reported this incident immediately to the registered manager and to the local safeguarding authority.
- On some days and nights there was a higher percentage of agency workers than permanent staff. This meant the consistency of support people received was negatively impacted on.

This was a breach of regulation 18 (Staffing) and regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the nominated individual and senior management team undertook quality assurance audits on all staff training and recruitment records and organised essential training courses. We also received feedback from health and social care commissioners which showed they had observed staff attending training sessions during their visit to the service.

Using medicines safely

- The provider failed to ensure medicines were consistently managed in a safe way.
- The registered manager had deployed care staff to administer medicines without essential training or experience. Care staff told us registered nurses and senior care workers asked them to administer medicines on their behalf. During the inspection we observed an agency registered nurse allow administration of a person's medicines by a care worker without their oversight. This meant they were secondary administering medicines and they could not be sure the person had taken them.
- Information about medicines given to people in a covert way (disguised in food or drink) was not robust or readily available for the member of staff administering. This meant people were at risk of not receiving their medicines as prescribed.
- We found evidence of medicine omissions without investigation. Information about medicines prescribed on a when needed basis was not sufficiently detailed. This meant people were at risk of not receiving their medicines as prescribed, and this risk was significantly increased with the high use of agency workers.

We found evidence that people's welfare had not been significantly affected by unsafe medicines administration practices, however, systems were either not in place or robust enough to support safe medicines management. This placed people at risk of harm.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the nominated individual and senior management team immediately discontinued the use of senior support workers for the administration of medicines and reviewed their medicine processes including information available for staff when administering medicines.

Preventing and controlling infection

- People were not being safeguarded from the risk of transmission of Covid-19 and other infectious disease because of inadequate infection prevention and control processes. A high number of staff across both days of the inspection demonstrated non-compliance with use of essential Personal Protective Equipment (PPE).
- We observed staff supporting one person without using essential PPE this placed them at an increased risk of Covid-19 transmission. This meant the individual, staff and other service users were also placed at risk of harm.
- The registered manager had failed to keep robust records in relation to the management of Covid-19 despite a suite of risk assessments, infection trackers and procedures being implemented by the provider. The registered manager also failed to assess the risk for staff and service users from Black Asian and Ethnic Minorities.

We found no evidence that people's welfare had been significantly affected by unsafe infection prevention and control however, systems were either not in place or robust enough to prevent the risk of infectious disease transmission. This placed people at risk of harm.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the nominated individual and senior management team took immediate steps to improve processes for infection prevention and control. They also updated us after the inspection and said they had seen improved staff compliance with the use of essential PPE. We have also signposted the provider to resources to develop their approach.

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.

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

- People's needs and choices were not always assessed to ensure their care, treatment and support was delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes. There were significant shortfalls in the assessment of people's mental health needs and management of behaviours that challenge and cause them distressed reactions.
- The provider did not ensure they could meet the needs of people with complex and unpredictable mental health illness. There was a lack of specialist assessments including care planning to support people when they were resistive to essential personal care, this lead to unsafe practices and incidents of violence and aggression placing people and staff at risk of harm.
- Since the beginning of the Covid-19 pandemic the registered manager had admitted 35 people to the service, this placed staff under undue pressure and meant they did not have the time to learn about people's individual needs and preferences. One member of staff told us, "I think the agency staff are thrown in at deep end and don't know the background of people and how to handle them or calm them down."

We found people's welfare had been significantly affected because their person-centred needs had not been effectively assessed. Systems were either not in place or robust enough to ensure specialised support was provided. This placed people at risk of harm.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff were not adequately supported with induction into their role and responsibilities. Staff told us they did not feel adequately trained or skilled to effectively care for people they supported.
- Staff consistently told us they felt unsafe at work because of the types of behaviours some people displayed including physical aggression. For example, a member of staff told us, "I have received training with moving and handling only, nothing else. No MAPA (Managing Actual and Potential Aggression) training at all. I only know what some staff tell us or pass on. I do hold people's hands for reassurance, I feel uncomfortable doing this, I have had to hold some people (restraint) but I don't like to as I know you can do it wrong and leave marks. I don't want to hurt people. But if they're agitated, I have to hold them to change them. I need the training, I am not sure when it will be though".

There was a failure to ensure that all staff had received appropriate support and training to enable them to carry out the duties.

This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the provider arranged training for staff, including agency workers in MAPA and Positive Behaviour Support (PBS). All other mandatory training was scheduled and completion was being regularly checked by local authority and health care commissioners.

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.

- Consent to care and treatment was not consistently sought in line with legislation and guidance. Some staff told us about their participation in unplanned control and restraint techniques and we also observed this during the inspection.
- Care records showed MCA assessments however, DoLS and MCA assessments for some people on continual supervision and control had not been considered.
- A person's legal representative told us they did not feel involved or kept up to date with decisions made about the service user they represented.

There was a failure to ensure people were effectively supported in line with principles of the MCA and associated DoLS.

This was a breach of Regulation 11 (Consent to care and 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

- People were supported to eat and drink enough to maintain a balanced diet. People told us they had choice and control at meal times however, there had been a period of time when access to food and drink at night time had been restricted by the registered manager. This was improved with immediate action taken during the inspection.
- People's care plans showed nutritional assessments and monitoring of nutritional risk. People's dietary likes and dislikes were recorded.
- We observed staff kindly support people during meal times and offered them extra portions. People's representatives told us, "The food is wonderful. It looks lovely", "The food is good, I used to eat there sometimes, and the staff always encourage her to eat" and "The food is okay and they seem to have plenty of snacks and drinks".

Supporting people to live healthier lives, access healthcare services and support; Staff working with other

agencies to provide consistent, effective, timely care

- There was evidence of partnership liaison in people's care records however, we found evidence which identified the registered manager had not always shared correct or transparent information with partner agencies. For example, safeguarding enquiries were raised with the registered manager in relation to the mismanagement of a person's diabetes, the recommendations and actions set by the local safeguarding authority were not acted on or shared with senior leaders in the organisation to ensure good governance.
- Staff referred people to their GP and other community health care professionals when needed. There was evidence of partnership working with health agencies including; podiatry, opticians and speech and language.

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

- There had been substantial consideration around the adaptation, design and decoration of premises for people living with cognitive and sensory impairment. People on all units could access outdoor areas and had plenty of communal space to walk with purpose.

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 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.

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

- We received mixed feedback from people's representatives, some told us they were very happy with the support people received others told us they were concerned about their relative's safety and the competency of staff supporting them. Our observations showed that people were not always treated with kindness, compassion and respect. Staff did not always have the right skills to engage and support people living with dementia in a compassionate and sensitive manner. This had led to negative experiences for people living at the service.
- People were not adequately protected against the risk of abuse from other people who lived at the service. There had been instances where vulnerable people were continuously targeted by others and action had not been taken to protect them. We also observed physical restraint was used before other alternative ways of supporting people such as de-escalation were considered. This meant people's human rights were not always protected.
- People, along with relatives, had been given the opportunity to share information about their life history, likes, dislikes and preferences. However, this was not always used to deliver person-centred and dignified care.

There was a failure to ensure that people were treated with respect, dignity and their human rights considered at all times. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

- People were not always supported to express their views and be actively involved in making decisions about their care, support and treatment as far as possible. Feedback from two people we spoke with showed that they were 'directed' to do things and felt 'dictated'. This approach did not promote choice and independence.
- Some people and/or their relatives told us that they were involved in discussions about their care. However, some expressed that staff they spoke to did not always show compassion especially if they were sharing information regarding an incident involving their relatives.

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 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.

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

- People did not always receive personalised care that was responsive to their needs. Following admission to the service there was a lack of support planning that centred the person's capabilities and preferences alongside their need for effective support. For example, one person's care plan identified staff should 'distract' the individual when they were distressed or anxious however, the plan did not clearly outline what distraction techniques were needed or known to help them. We observed staff using unplanned restraint for this person and staff were unable to tell us what distraction techniques had been tried.
- We observed staff use unplanned segregation for another person who was distressed, staff were unable to tell us what least restrictive options were considered before segregation and they were also unable to tell us what positive actions they could have taken to distract and effectively support the person. Staff lacked knowledge about how to support the individual in a person-centred way and this had a significant impact on their wellbeing.
- Staff told us they understood very little about people's needs or preferences and had no time to read their care plans. We found staff were not allocated in a way to ensure consistency for people living with memory loss which meant staff and service users were unable to form trusting relationships and familiarity with those supporting them.

There was a failure to ensure people received person-centred care. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the senior management team implemented quick reference profiles which showed new or agency care workers how to engage with the person in a person-centred way, the development of this information was ongoing because a high number of people needed to be fully assessed with the involvement of external health and social care professionals.

- People's needs and preferences were obtained prior to admission and requests to gather life story information were sent to their representatives if they were unable to inform staff themselves.

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

- We received mixed feedback from people's representatives in relation to the way staff enabled them to maintain relationships with their friends and family. Negative comments included, "There is supposed to be a phone system set up for you to speak to your relative but you only get put through to a desk and they don't answer the phone on the unit. They have given me a few numbers to ring but usually you can't get through. If

you do get through, they say they will go and get someone but they don't and they don't ring back. It is very distressing", "I had phone calls booked for [various times] to face time my [relative]. They very rarely happen because they don't answer the phone" and "They seem to have a lot of agency staff and they don't understand what I am saying or what my [relative] and I are saying when we are on a face time call. I think the communication is poor".

- Positive comments included, "The staff said they would let me know if anything was concerning them about my [relative] so that is good" and "I think they have gone above and beyond setting up a video call. They phone me up and ask if I am available to talk to my [relative]".
- People had access to meaningful activities when they were scheduled. Some people told us they would like to engage more in routine life skill activities to maintain their independence, this was restricted to scheduled times rather than being part of their daily routine.

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.

- The provider had processes in place for assessment of people's communication needs and preferences. The environment was designed specifically for people who lived with dementia and enabled orientation with means of good signage and themed areas for reminiscence and social activity, for example reading or engaging with tactile objects.
- Staff assessed people's communication abilities during their pre-admission assessment and then on a monthly basis. People had access to specialist professionals to ensure their physical health was assessed and support provided when needed for their vision, hearing and speech.

Improving care quality in response to complaints or concerns

- People's concerns and complaints were listened to. We found people and their representatives were satisfied with the way senior management responded to their concerns. During the inspection the senior management team noticed the complaints procedure had been removed from its usual place on display in the service, the procedure identified contact details for head office staff, should any stakeholder want to escalate concerns above home management level. This was reinstated.

End of life care and support

- People's end of life wishes, and needs were considered. Advanced care planning was in place for some people and this had been undertaken in a person-centred way.
- There was a procedure in place for staff to consult when a person needed end of life care and support. Staff told us they had received or were scheduled to undertake end of life care training.

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 this newly registered service. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The registered manager did not demonstrate their understanding of quality performance and regulatory requirements. While the registered provider had established systems and processes to monitor quality and to assist in complying with regulations, the registered manager had not followed these systems. Instances of poor, unsafe practices or safeguarding's were either not reviewed or escalated to senior management which resulted in a significant deterioration of the standards of care provided. Staff had not been provided with robust and responsive leadership by the registered manager.
- The provider's quality assurance systems and audits were in place however they had not been fully operational due to Covid-19. Quality visits had been restricted to remote monitoring. Although there was a system for checking quality remotely, the registered manager had withheld concerns and key information which did not provide the senior managers with an accurate reflection of the challenges at the service. This had an impact on the ability of the provider to continuously monitor and improve people's experiences and the care provided. Where audits had been carried out, the findings were not used to improve the safety and quality of care.
- Systems for learning from incidents and near misses had not been adequately implemented which meant staff could not demonstrate whether they had reviewed what could be learnt from incidents events to reduce re-occurrences. This led to repeated themes of people experiencing poor care and inappropriate treatment from others.

There had been a failure to assess, monitor and improve the quality, safety and welfare of service users and others who may be at risk. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The registered manager had created a closed culture which did not promote the provision of high-quality, person-centred care and transparency. Poor care practices were reported but were not challenged or investigated by the registered manager. Staff were discouraged from raising concerns or to challenge poor practices with senior managers. Systems for supporting staff including inductions, supervision and appraisals were not implemented to support the delivery of safe care.
- The registered manager had submitted some notifications to the Care Quality Commission however we found a significant number of concerns and safeguarding concerns had not been shared with CQC or the

local authority. This meant that CQC could not undertake its regulatory function effectively.

This was a potential breach of regulation 18 (Notification of other incidents) of Care Quality Commission (Registration) Regulations 2009.

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

- The registered manager and senior management team told us they encouraged feedback from people and staff. However, our findings showed that feedback from staff on the quality of care and their experiences was not always welcomed. Staff told us there were afraid of raising concerns for fear of retaliations from their line managers. The nominated individual and senior management team took immediate action to address this during the inspection.
- The provider had not fully established practices and procedures to ensure peoples equality characteristics of disability in respect of dementia care were being considered and supported in line with their needs.
- While the registered manager had developed links with a variety of professionals, the information they shared was not always transparent to reflect the experiences of people living in the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had failed to ensure care and treatment was provided in a person-centred way for service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had failed to ensure care and treatment was provided in a dignified and respectful way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had failed to ensure care and treatment was provided inline with principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to ensure care and treatment was provided in a safe way for service users and there was a failure to assess the risks to the health and safety of service users of receiving the care or treatment; including doing all that is reasonably practicable to

mitigate any such risks.

The provider failed to ensure people's medicines were consistently managed in a safe way.

The provider failed to ensure people were protected from the risk of infection, including the transmission of Covid-19.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure care service users were consistently protected from abuse, harm and improper treatment.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure robust quality assurance of the service. The service was not well led.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure staff working with vulnerable adults were screened for good character before they were employed.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff had the essential skills, competency and experience to provide service users with safe and effective care and treatment. The provider failed to ensure suitable numbers of skilled staff were deployed.

