SHC Clemsfold Group Limited

Horncastle Care Centre

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:

Horncastle Care centre is a residential care service that is registered to provide accommodation, nursing and personal care for people with learning disabilities or autistic spectrum disorder, physical disabilities, younger adults. The service also provides support for people with acquired brain injury and neurological disabilities.

Horncastle Care Centre is owned and operated by the provider Sussex Healthcare. Services operated by Sussex Healthcare have been subject to a period of increased monitoring and support by local authority commissioners. Due to concerns raised about the provider, Sussex Healthcare is currently subject to a police investigation. The investigation is on-going, and no conclusions have yet been reached.

Horncastle Care Centre had been built and registered before the Care Quality Commission (CQC) policy for providers of learning disability or autism services 'Registering the Right Support' (RRS) had been published. The guidance and values included in the RRS policy advocate choice and promotion of independence and inclusion, so people using learning disability or autism services can live as ordinary a life as any other citizen.

The service was registered for the support of up to 20 people. At the time of the inspection 16 people were using the service, including one person who was receiving short-term respite support. This is larger than current best practice guidance.

The service consisted of two separate bungalows, Maple and Willow Lodge, and was in private grounds between two small villages. Both bungalows had capacity for up to ten people to live in them and were bigger than most domestic style properties. There were identifying signs on the road before the service's private drive, the service grounds and on the exterior of each bungalow to indicate it was a care home. Staff wore uniforms and name badges to say they were care staff when coming and going with people.

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

The service did not consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; People did not always receive personalised care. People did not always plan, review or develop their individual support needs and wishes. People did not always have support with meaningful activities. People's communication needs were not always met. Language in people's care plans was not always respectful of their disabilities or support needs. Staff did not always support people with dignity or to

be as independent as they were able to be.

People were not 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 always support this practice.

Risks to people were not always adequately assessed, monitored and managed, causing or exposing people to risk of harm. Staff practice and reporting systems to safeguard people from abuse were not always effective. Lessons were not always learnt, and actions taken to investigate safety incidents and act to prevent them re-occurring. Medicines were not always managed safely.

People were not being always being supported to achieve effective support outcomes. Best practice guidance was not always considered when assessing people's needs, or what people wanted from their support. Staff did not always have the right skills, knowledge or experience to deliver effective care to people. People's day to day health and well-being needs were not always monitored or met effectively. Staff did not always work well with other agencies. People's dignity and independence was not always respected or promoted. Staff did not always seek accessible ways to communicate with people.

People's strengths, levels of independence and quality of life was not always accounted for when planning and reviewing their care. People were not always involved in planning and reviewing their care. People did not always have support to identify and achieve individual goals and wishes. Care plans did not always record when people's support needs had changed, so staff could access up to date information about these changes.

The service was not always meeting the communication needs of people with a disability or sensory loss. People did not always have support with meaningful activities or to access the community to take part appropriate social activities. People did not always have support to maintain or develop meaningful relationships.

Systems and processes to assess, monitor and improve the quality and safety of the service were not operating effectively. The provider had not ensured that staff at all levels understood their responsibilities and managed staff accountability effectively. Staff had not always shared appropriate information with other agencies for the benefit of people. Leadership at all levels at the service was not always visible and did not always inspire staff to provide a quality service. Staff had not always displayed values consistent with the provider's vision of delivering high quality, person-centred care.

Some people and relatives we spoke with were very positive about the support they received at the service. One person said, "I never feel unsafe." There were processes to help ensure staff were safely recruited. There were enough numbers of staff. People were supported to prevent and control hygiene and infection risks. People had support to have a balanced diet and the correct nutrition. The adaptation, design and decoration of the premises met people's individual needs.

We observed staff supporting people in a caring and patient manner. People had support to access independent services to help them understand, answer questions and speak for them if necessary. Relatives told us if they had ever raised any concerns or complaints, these had been responded to well and they had been happy with the outcome. People's views and experiences were being gathered to help gain their ideas about how to improve the service.

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

Rating at last inspection

We last inspected this service in February and March 2019. The service was rated Inadequate (Published 9 May 2019). There were multiple breaches of regulations and the service was placed in special measures.

A previous inspection in April 2018 identified multiple breaches of regulations and rated the service Requires Improvement.

Following this inspection, the service remains rated Inadequate, with multiple breaches of regulations and in remains in special measures.

The service has now been rated Inadequate for two consecutive inspections. There have been multiple breaches of regulations identified at three consecutive inspections.

Horncastle Care Centre has been placed in special measures since May 2019. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. Services in special measures will be kept under review and, if needed could be escalated to urgent enforcement action.

Why we inspected

This was a planned comprehensive inspection based on the previous rating.

This inspection looked to see if the provider had acted to make significant improvements to achieve compliance with regulations.

Enforcement

At this inspection, we have identified seven continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulations 9, 10, 11, 12, 13, 17 and 18 in relation to: person centred care, dignity and respect, safe care and treatment, consent, safeguarding people from abuse, good governance and staffing.

We have also identified that the provider has not notified the CQC as required to inform them of a registered manager's absence for more than 28 consecutive days. This is a breach of CQC (Registration) Regulations 2009 regulation 14 (Notice of Absence).

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The provider's appeal to the Notice of Decision with withdrawn in June 2020 and the enforcement action to remove the registration of this location took effect. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider.

The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

Follow up

The overall rating for this service is 'Inadequate' and the service therefore remains 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? The service was not safe.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Horncastle Care Centre

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.

Inspection team

This inspection took place over two days on 28 and 29 August 2019.

On 28 August 2019 the inspection team consisted of two inspectors, a registered nurse specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On 29 August 2019 the inspection team consisted of three inspectors and a registered nurse specialist advisor.

Service and service type

Horncastle Care Centre is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided.

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.

At the time of the inspection, the registered manager had been absent from managing a regulated activity at the service for more than 28 consecutive days.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

Before the inspection, we reviewed information we held about the service. We considered the information which had been shared with us by the provider as well as the local authority, other agencies and health and social care professionals.

We looked at any safeguarding alerts which had been made and notifications which had been submitted by the provider. A notification is information about important events the provider is required to tell us about by law. This is necessary so that, where needed, the Care Quality Commission (CQC) can take follow up action.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection

During the inspection we spoke with six care staff, four registered nurses, the activities assistant, the chef, the deputy manager, and the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We 'pathway tracked' six people using the service. This is where we looked at people's care documentation in depth and obtained their views on how they found the service where possible. This allowed us to capture information about a sample of people receiving care.

We spoke with three people using the service and observed people's support across all areas of the service.

We spoke with two relatives of people who were visiting the service.

We spoke with a GP and a community NHS dietician who were supporting people at the service.

We reviewed staff training and supervision records, staff recruitment records, medicines records, care plans, risk assessments, and accidents and incident records.

We also reviewed quality audits, policies and procedures, staff rotas and information about activities people were supported with and provided by the service.

After the inspection

We asked the provider to send us information to help validate evidence found.

We asked the provider to send us information in relation to an allegation of abuse of service users living at Horncastle Care Centre. This incident is subject to a criminal investigation and as a result CQC did not examine the specific allegations made. However, the information shared with CQC about the incident

indicated potential concerns about safeguarding and how the provider was protecting people from the risk of abuse. We examined this risk as part of this inspection.

We spoke with three relatives via telephone.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management, learning lessons when things go wrong, using medicines safely

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people, manage medicines safely and learn lessons and make improvements when things go wrong.

We had found specific concerns about people's safety regarding risks associated with choking and aspiration, epilepsy, skin integrity, behaviours that may challenge and constipation.

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

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management

● There was not always guidance or information to help staff understand how to support people to safely manage their constipation needs. Elimination care plans did not always contain details regarding people's usual bowel habits, risk factors or how healthy bowels were promoted.

●Actions that had been identified to help keep people safe if they became constipated were not always taken by staff. A person had recently experienced constipation over a period of nine days. During this period, staff did not offer medicines or seek medical advice at the correct times, as per directions in the person's constipation risk assessment and medicine protocol. This resulted in the person needing admission to hospital for emergency treatment.

● Risks to people with epilepsy were not always being monitored, assessed or managed safely, exposing them to risk of harm. There were inconsistencies in seizure monitoring documents and information in people's epilepsy care plans. This increased the risk that staff may not know how often people were experiencing seizures and check they were getting the right support when they did. Different advice in care plans increased the risk of people receiving inconsistent support that may not meet their needs safely.

●There were no epilepsy risk assessments for people, so staff did not always know the safest way to support

people with their epilepsy needs. For example, some people who were wheelchair users were prescribed medicine to be taken rectally if they had a long period of seizure. Staff told us a person had recently been hoisted and transferred out of their wheelchair by several staff whilst in seizure, to give them rectal medicine. Staff confirmed they had done this despite having no guidance about how to do this as safely as possible. This had placed the person at increased risk of avoidable harm.

● Risks relating to people's physical and non-physical challenging behaviours were not always assessed, monitored or managed safely, increasing the risk of harm to people. The functions behind people's challenging behaviours had not always been assessed. One person whose known behaviours could harm themselves or others had no assessment or care plan for staff to follow to minimise this risk. Other people had only basic behaviour support plans. These contained little guidance about how to support them to prevent their behaviours that may challenge from occurring or escalating.

● People who displayed behaviours that could challenge were at risk of not being supported safely or in the least restrictive way. Four people were regularly separated from other people by staff to de-escalate their behaviours that could challenge. However, these interventions had not been risk assessed and there was no clear procedure for staff to follow. Incidents where staff kept people apart from other people after they became challenging were not formally monitored or reviewed, to check this was always being done safely.

●Risks to people of choking were not always monitored or managed safely. Not all staff had been trained how to operate equipment that was in use to help prevent people who were choking from serious injury or death. Not all staff we spoke with told us they knew how to operate this equipment. We observed staff not supporting a person to position their head in a neutral position as per their guidelines whilst eating and drinking, increasing the risk of choking.

●Risks of aspiration (breathing in liquids, food or saliva) and infection for people with PEG support needs were not always assessed, monitored or managed safely. A percutaneous endoscopic gastrostomy (PEG) is a tube that is inserted into a person's abdomen, so they can receive liquid food, fluids and/or medicines directly to their stomach.

●One person who was fed via a PEG tube required to be sat up, or elevated at a specific angle, whilst in bed to reduce the risk of aspiration. There were inconsistencies about the correct angle they should be elevated to in the person's care plans. This increased the risk staff may not know or support them to be sat up at a safe angle, increasing the risk of aspiration.

●Staff told us they thought all staff always elevated the person during the night but did not know at what angle. However, staff were not recording they were elevating the person at night or at what angle, so it was not able to be confirmed they had been supported safely.

●Staff told us they thought a person was always being supported with their required daily PEG site cleaning and weekly PEG tube advance cleaning. However, although other PEG care tasks were recorded, staff were not recording they were carrying out these tasks. Because of this, it was not possible to confirm the person had been supported to reduce the risks of infection.

●Actions that had been identified to manage risks to people with postural support and mobility needs were not always being carried out, increasing the risk of harm. One person required regular physiotherapy but had not been receiving this support as often as they needed. This increased the risk they may not maintain their current range of movement and avoid discomfort.

●Postural support equipment for one person had been issued without guidance and was out of use due to potential risk of harm if it was not fitted correctly. Staff had been instructed not to use the equipment until the guidance was provided. However, during the inspection we observed staff supporting the person to fit and use this equipment without guidance. When we spoke with the staff member, they were not aware this equipment should not have been used.

●Staff were not always following systems and adequate guidance was not always in place to protect people at risk of skin damage. This exposed people to risk of harm. It was not always recorded how people were being re-positioned as often as they needed to be, to confirm staff had supported them to minimise the risk of possible pressure damage. There were inconsistencies and a lack of guidance in people's care plans about how to manage risks of skin breakdown. This increased the risk that staff may not know or be able to know how to support people safely.

Using medicines safely

●Medicines were not always managed safely, placing people at risk of harm. A review of internal and external incident reports and audits showed that since the last inspection there had been repeat errors in medicines management. People had not been given medicines when required, staff dispensed medicines to people they were not prescribed for and people did not have access to the correct medicines.

●We had been made aware through safeguarding enquiries of at least two occasions where a person was given medication belonging to someone else during a period of leave from the service. This had been raised by relatives of service users affected who noticed the error and were able to prevent the person from taking the wrong medicines.

●Medication administration records (MAR) were not always completed in line with best practice guidance. When medicines had not been given to people as prescribed, it was not recorded why this was or what action was taken. The MAR for people who were nil by mouth(not able to take food or fluids orally) and at risk of aspiration directed staff to administer prescribed liquid medicines orally. Having an incorrect route of administration on MAR could increase the risk of error. In this case, it could increase the risk of the person aspirating. Staff told us they did not think the person had been supported to take medicines orally. However, staff had signed the MAR to show they had administered the medicine orally, so this was not able to be confirmed.

●Medicine auditing systems were not always effective. Comprehensive audits were completed daily, weekly and monthly. Audits were designed to check that specific areas of practice, including information about medicines, MAR completion and administration of medicines were being carried out safely. We checked the same areas of practice during this inspection and saw audits had not had identified errors which we found.

Learning lessons when things go wrong

● Systems in place for staff and management to report, review investigate safety incidents and act to prevent them re-occurring were not always effective. This increased the risk that incidents would not be investigated and acted on to prevent them from happening again. There were several different accident and incident reporting forms in use. Staff were not always completing these consistently or reporting incidents internally or externally for further review.

● During this inspection, we identified issues relating to safety incidents that had either not been reported or

had not been acted on. For example, MAR not being completed correctly, and medicines not being given had not been reported. A person had been hoisted to administer emergency rectal medicine without guidance about how to do this as safely as possible. There had been no immediate action to ensure there was a formal risk assessment and management procedure for staff to follow should the incident occur again.

●Risks associated with PEG care, choking and aspiration, epilepsy, skin integrity, behaviours that may challenge and constipation were found at inspections April 2018 and in February and March 2019. We also found concerns regarding safe management of medicines and failing to learn and make improvements when things had gone wrong at both these inspections. At this inspection, we had found the same risks and safety concerns were continuing and the provider had failed to act upon these known areas of concern to improve safety for people.

●The themes of risks and concerns found at this inspection relating to PEG care, choking, aspiration, skin integrity, epilepsy, behaviours that may challenge and constipation have been highlighted in inspection reports about many of the provider's other services. This information had not led the provider acting to prevent similar risks to people at Horncastle Care Centre being reduced.

The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users, ensure safe and proper use of medicines and thoroughly review, investigate, monitor and act to make improvements in relation to incidents that affect the health safety and welfare of service users. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our visit on 29 August 2019, we asked the provider for immediate assurances about how they would address the inadequate risk management and unsafe support for people with constipation and epilepsy. The provider sent us information on 30 August 2019 detailing urgent and on-going actions they would take in response to these concerns.

● We spoke with a healthcare professional who regularly worked with people at the service during this inspection process. They raised concerns that, in their recent experience, people's fluid charts continued to fail to evidence they had enough to drink and could remain at risk of dehydration.

●During the previous inspection, we found it was not being documented that people were receiving adequate fluids and could be at risk of dehydration. Our findings from this inspection indicated the provider had made some improvements. People had been recommended daily allowances (RDAs) of fluid intake and the amount of fluid people were taking was being recorded. Peoples fluid monitoring charts we looked at showed recommended daily allowances of fluids and that people had achieved these.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure systems and processes protected people from abuse 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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

●Systems in place for staff and management to report, review and investigate safety and safeguarding incidents were not always effective. There had been instances of unexplained bruising and people experiencing extended periods of constipation that had not been reported or acted on.

●Since the last inspection, there had been several safeguarding issues raised by relatives or partnership agencies after visiting the service. The provider had not been aware of and had not been taking appropriate steps to prevent these safeguarding issues before these alerts were raised. Subsequent safeguarding investigations by partnership agencies in response to the alerts had found people had been subject to abuse and improper treatment.

●For example, people had been placed at risk of harm due to staff not providing their epilepsy, medicine and manual handling support safely. People had incorrect and unsafe manual handling equipment in use. A person had fallen while being hoisted. People had not been dispensed medicines that were not prescribed for them due to staff error. There had been multiple recording issues and concerns that appropriate healthcare monitoring had not taken place during and post seizure when further medical intervention may have been necessary.

The provider failed to ensure systems and processes protected people from abuse and improper treatment. This is a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People who were able to verbally communicate with us told us they felt safe. One person said, "I feel extremely safe." All relatives we spoke with were very confident their family member would communicate with them and they would recognise if they were upset or distressed. They all said although they regularly visited, and often unannounced, they had never had any concerns about people's safety.

● The deputy manager said that since the last inspection, they had been placing an emphasis on safeguarding and promoting the importance of reporting any abuse concerns immediately with staff during informal supervisions and conversations.

● The deputy manager and provider's nominated individual told us they had begun to do more to raise awareness amongst people who lived at the service about how to recognise and report abuse concerns. They said that there had been informal and undocumented conversations between staff and people.

●There was information about how people using the service could raise safeguarding concerns on communal noticeboards. There had been one instance since the last inspection where a person was supported to raise a formal safeguarding concern after raising abuse concerns with staff.

Preventing and controlling infection

●There were arrangements in place to ensure the service was clean and hygienic. The provider employed cleaning staff who carried out daily cleaning of all areas and equipment in use at the service. Plastic gloves and aprons where available and staff used these when supporting people with their personal care. People and relatives did not raise any concerns regarding hygiene or cleanliness at the service.

●There were separate catering staff and both they and support workers received food hygiene training to help ensure food was handled and prepared safely.

Staffing and recruitment

●There had been recent turnover of staff. Agency staff were employed to cover permanent vacancies until these had been recruited to. During the day, at least one permanent registered nurse was deployed in the service. Wherever possible, the same agency staff were booked for continuity. However, we have raised concerns about the skills and competencies of staff deployed in other sections of this report.

●Rotas had been written to allocate staff, based on the provider's calculations of the levels of support people needed. People and staff did not raise any concerns about staffing levels. One relative said, "There are staff available and they respond." Another relative said in their opinion, "Staffing levels do not feel unsafe."

● All staff working at the service had undertaken a satisfactory Disclosure and Barring Service (DBS) check. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting. Permanent staff submitted applications, references and passed a competency-based interview prior to being offered a position.

● All nurses working at the service had a valid registration pin number with the Nursing and Midwifery Council (NMC). The NMC regulates nurses and midwives in the UK against their set standards of education, training, conduct and performance. A valid NMC registration helps ensure nurses have mandatory nursing knowledge, training and skills and uphold expected professional standards.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now remained the same.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection staff had not always received appropriate training to enable them to carry out their duties they are employed to perform.

We found specific concerns regarding a lack of training about how to effectively meet people's specialist healthcare conditions, including Huntington's Disease, multiple sclerosis and epilepsy. We found staff had not received training about how to best meet people who required support with behaviours that may challenge.

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

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Staff did not always have the right skills, knowledge or experience to deliver effective care to people. Agency staff who regularly worked at the service and permanent staff had not always received training in subjects relevant to supporting people at Horncastle Care Centre. This included: positive behaviour support, communication, suctioning, de-choking devices, learning disabilities, equality and diversity and multiple sclerosis. Failure to ensure agency staff had the appropriate knowledge and competencies in key areas of people's care had been highlighted at previous inspections but had not improved.

●During the inspection, we observed instances where permanent and agency support staff and nurses were not aware of how to meet people's assessed needs, preferences and choices. Some people had been assessed as specifically requesting to receive cardiopulmonary resuscitation (CPR) in the event of a medical emergency. Nurses we spoke with during the inspection could not tell us the correct technique and process to administer CPR to people who might need it. Other staff we spoke with could not explain people's behaviour support guidelines and the recognised directions to follow if people became challenging.

●A person we spoke with told us there could be issues with the way staff communicated, which increased the chances their care would not be effective. They said, "It is preferred if they can speak English. (There

have been issues) not just with me, with other people."

●A GP told us they experienced similar concerns. They said, "I've had to ask lady from the other lodge to come as the locum (agency) nurse today was difficult to give instructions to." A staff member said some staff for whom "English (language) was a problem" might not always complete accident and incident report forms, even if they were responsible for doing so.

● There were high numbers of permanent registered nurse and support worker vacancies and long-term absences at the service. The service relied on agency staff to cover shifts every day. We requested rotas between July, August and September. We were given rotas for the periods; 3 June to 30 June 2019, 1 July to 28 July 2019 and 26 August to 22 September 2019. These showed each week at least 50% of registered nurses working day and night shifts were agency nurses. There were concerns raised during this inspection that agency staff working at the service who did not have relevant skills, knowledge and experience to be able to meet people's needs. A relative said, "Agency staff don't know people very well, they are not the best, they are not on the ball."

●A GP who visited the service every week told us, "My concern is the lack of regular nurses. They don't know the patients very well. The delivery of care is not the same standard. If I say; 'make sure patient's PEG site is cleaned 3 or 4 times a day' and its not been done, you trace it back to locum (agency) nurse being on site for couple of days."

●Following the imposition of conditions of the provider's registration in December 2018, the provider must send CQC, monthly information, including about staffing. These reports consistently contain information that, each month regular agency staff are provided with additional training to maximise their competencies and knowledge. Recent reports highlighted deployment of staff was being monitored using an analysis tool to check shifts were covered by staff with the right skills.

●However, records sent to us by the provider following the inspection show only one of five agency staff who regularly worked at Horncastle Care centre had received additional training since the last inspection. This training was for tracheostomy care which no person using the service required support with. Only one other regular agency staff had received additional training in 2019 and this was for use of a de-choker device. Only one other staff had received additional training in subjects relevant to people's needs at the service, in epilepsy and PEG care, and this was in October 2017 and November 2018.

●Due to the high number of permanent nurse vacancies and inconsistencies in agency and non-permanent staff's training, skill set and knowledge about people and their needs, we were told the service aimed to always have at least one permanent nurse on shift. However, rotas we sampled for the periods between June and September showed at times night shifts had been solely covered by bank and agency staff. There was regularly only one permanent nurse working during the day and for all but two nights to cover shifts.

●Each separate bungalow regularly only had one permanent nurse available, so in the event of agency staff needing any information and advice, this could only be gained by physically leaving the bungalow and walking to the other one. This further increased the risk of a delay in staff being able to provide effective support for people, including in an emergency. This also created additional pressure and distraction for the permanent nurses, which impacted on their own ability to deliver effective care.

●This was the third consecutive inspection since April 2018 where the service had failed to ensure staff had the skills, knowledge and experience to deliver consistently effective support for people. At this inspection,

we had found the same risks and safety concerns were continuing and the provider had failed to act upon these known areas of concern to improve safety for people.

●The themes of risks and concerns found at this inspection relating to staffing had been highlighted in inspection reports about many of the provider's other services. This information had not led the provider acting to prevent similar risks to people at Horncastle Care Centre being reduced.

The failure to deploy and staff who had received appropriate support, training and personal development and evidence that the service had assured themselves of their competence to carry out the duties they are employed to perform is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014."

●Permanent staff had received training as well as regular supervisions and inductions from the deputy manager since the last inspection. Most staff had recently received some specialist training to help them understand and support people at the service with the condition of 'Huntington's disease' more effectively.

●The provider was reviewing the induction and on-going management of agency staff, to include more regular clinical competencies and more robust systems for ensuring they had the right training and skills to meet people's needs. This was not yet embedded in practice and had not yet been effective in ensuring the staff deployed consistently had the right knowledge and skills to support people with their complex needs.

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

At the last inspection, the provider had not ensured service users consent to care and treatment had been sought in accordance with legislation. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

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

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

● People's consent to care and treatment had not always been sought in line with the MCA. Where people might lack mental capacity to be able to make certain decisions, this had not always been assessed. For some people, this included a lack of mental capacity assessment regarding decisions about specific healthcare treatment and medicines they received and forms of restraint they were subject to.

●For some people, there was a record that a person with authority to act in their best interests had been

identified and involved in making specific decisions about their care. However, there was not always a corresponding capacity assessment to confirm the person's inability to consent to the decision, before the best interest meeting had taken place. For example, a best interest meeting with external health and social care professionals had been arranged regarding a person's specific healthcare needs including dentistry and healthcare screening. However, their capacity to be able to decide about these specific needs had not been assessed, they had only previously been assessed as lacking capacity to consent to hospital treatment.

●Where people had authorised DoLS, relevant DoLS conditions were not always clearly identified and staff were not always aware of who had them, or what they were. People's DoLS conditions were not always being met. One person's DoLS was subject to a condition regarding supporting them to take part in regular activities, including time spent outside, and for this to be recorded consistently. However, their activity records had not been completed consistently to confirm whether this condition was being adhered to. Where records had been completed, they did not evidence that the person had consistently received support to take part in regular indoor or outdoor activities in line with this condition.

The provider had failed to ensure service users consent to care and treatment had been sought in accordance with legislation. This was a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Best practice guidance was not always considered when assessing people's needs, or what people wanted from their support. Some people with behaviours that may challenge had not been supported to assess the reasons they may display behaviour that may challenge. This increased the risk that they might not be supported via preventative and positive interventions from staff and helped to reduce the risk they may be supported using to help avoid the need for using reactive and restrictive practices. This also increased the risk of an on-going negative impact on people's quality of life and their ability to learn new skills to replace their challenging behaviour.

●Assessments of some people's sexuality and mental health needs had not considered appropriate, evidence-based practical social support, advice and guidance. This increased the risk that they might not receive effective support to meet their needs in these areas of their lives. For example, one person with assessed sexuality needs wanted to develop relationships with people. The person had profound physical disabilities, an acquired brain injury, may require support to make informed decisions about specific choices and required full staff support to leave the service. However, their support needs to help ensure this outcome was achieved had been assessed as, "I like to wear colourful clothes, appropriate to my gender" and "I like to have a wet shave." This did not adequately explore how the person's needs could be met in this area and consider how risks could be mitigated.

● We did not observe any direct discrimination. However, for some people, it was not always evident their differences in relation to their support needs and choices had always been respected during the assessment process. For example, one person's behavioural support plan had identified one of their preferred outcomes as being, "to have a good quality of life despite my autism." This makes a disrespectful conclusion about how this condition limits the person from living a full and satisfying life.

● The failure to assess and design care to ensure people's preferences are achieved and their needs are met is a breach of Regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●The deputy manager told us the service was now starting to work intensively with partnership agencies, to help ensure effective professional knowledge and guidance was considered when assessing and designing people's care. They said this was a "huge shift" in the way the service had operated historically, and this would help change the "clinical culture" at the service. The provider's internal 'Positive Behaviour and Autism Lead' was planning to assess and develop effective behavioural support plans for people who did not have these.

Supporting people to live healthier lives, access healthcare services and support, Staff working with other agencies to provide consistent, effective, timely care

● People's day to day health and well-being needs were not always met effectively. One person had not been supported to have an annual health check, following a recommendation from external health and social care professionals that this was done. We have commented more on people's healthcare needs not being met in relation to constipation, epilepsy, PEG care, skin integrity, postural and mobility support in the safe section of this report.

●A GP who visited people weekly raised concerns regarding the ability of agency staff to meet people's day to day healthcare needs. A healthcare professional raised concerns their directions were not being followed consistently by staff and they were not confident people's healthcare needs were being always being met.

●Nurses and support staff monitored people's well-being daily by talking with people and observing their physical and emotional presentation. Nurses used a standardised system for recording and assessing baseline observations of people's health indicators called National Early Warning Score (NEWS). NEWS was designed to ensure people could be supported to receive or access healthcare support and services quickly.

● Not all permanent or agency nurses had received the necessary training to know how to use the NEWS systems. There had been incidents at the service since the last inspection where nurses at the service had not monitored people's healthcare needs or used NEWS correctly. This had caused an avoidable delay in people receiving further medical support as quickly as possible.

●Staff did not always work effectively with other agencies. Feedback from health and social care professionals about the service raised concerns about staff not working well within the service or with their agencies. A GP said, "It is difficult in terms of follow-through, sometimes you feel you are chasing or repeating things".

●A healthcare professional who had been referred to work with a person at the service said staff had repeatedly not been able to share or allow access to relevant information. This delayed them being able to help deliver effective support for the person.

● The failure to work effectively with other agencies and to ensure the health, safety and welfare of service users is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Recent NEWS charts we sampled during the inspection had been completed correctly and showed staff had supported people to access further healthcare support quickly, if necessary. The deputy manager and nominated individual told us further training and supervision was planned for nurses to help ensure their use of NEWS and healthcare monitoring was effective.

●People we spoke with did not raise any concerns the support they received with their healthcare needs. One relative we spoke with praised the way in which staff had supported their family member to meet their specific healthcare needs effectively. Another relative told us how the service had referred their family member to appropriate healthcare services, which had resulted in a long-standing health issue being resolved.

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

At the last inspection, the provider was unable to demonstrate that they had made reasonable adjustments to the premises in accordance with the Equality Act 2010 and other current legislation and guidance. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15.

● At previous inspections in April 2018 and February and March 2019 we had identified the provider had failed to make reasonable adjustments to allow people who used wheelchairs to move around freely. The provider had now installed electronic door open and closing devices to allow people to move around the premises independently.

●The premises had been designed to accommodate people with physical disability support needs. There were wide doorways and corridors to allow for wheelchair access. Equipment such as ceiling track hoists had been installed in individual bathrooms and bedrooms to support people with transferring from one place to another.

●There was a large central communal space and smaller communal areas in both bungalows, where people could eat and spend time taking part in activities or socialising. There were large outside gardens and smaller outside spaces outside of each bedroom that were wheelchair accessible. One person had been supported to create their own personal garden in the space outside their room, as gardening was something they enjoyed.

●There was appropriate signage on doors to toilets and other communal rooms and facilities, to help people find their way around the building. Communal areas were decorated with pictures created by and photographs of people. People had personalised their bedrooms with their own furniture and decorations.

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

●Risks to people with complex needs in relation to their eating and drinking were not always monitored or managed safely. We have commented on this in the Safe section of this report.

● People had support to have a balanced diet and the correct nutrition. One person who had been overweight was supported to make referrals to dieticians and speech and language therapists (SaLT). The had provided guidelines for a healthy eating diet and the person had been supported to follow this diet and had lost weight. Other people were weighed regularly, and their food and fluid intake monitored. Similar referrals were made if there were concerns about their nutritional needs.

●Food was prepared by a chef, who had access to and followed the directions in people's eating and

drinking guidelines. SaLT had delivered training to help advise them about the people's specific dietary needs and effective nutritional supplements. People were involved in developing menus, which changed regularly. People were offered different meal choices daily. The service could cater for any religious or cultural food preferences, if these were requested.

●People and their relatives did not raise any concerns about the quality of the food or having enough to eat or drink. One person said, "Yes, the food is very good." Meals were appropriately spaced throughout the day and mealtimes could be flexible to meet people's needs.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

At the last inspection, the provider was not ensuring that people were always treated with respect and dignity.

We had found staff entered a person's room without knocking and supported another person when eating in an undignified manner. A person told inspectors that they were not listened to and their choices not respected by staff.

This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 10.

● People's dignity and independence was not always respected or promoted. We observed two support staff supporting a person in an undignified manner when eating. The person was vision impaired. Their eating and drinking guidelines stated; 'Please do not 'wave' the cup or spoon in front of me. Just hold it to my eye line so I can see it'. However, both staff members were seen to be waving a cup and spoon in front of the person's face to get their attention.

●People's support documents and care plans contained disrespectful language towards people's health conditions and disabilities. For one person, an information sheet about their needs made disrespectful conclusions about the negative impact their disabilities and healthcare support needs were having on their dignity and independence. For example, removing communication barriers that were necessary due to their disabilities was not considered. Instead staff were only given information that; "I cannot communicate verbally so it will be difficult to understand."

● Other information about the person was viewed as 'things not working out' in the person's life, rather than being recognised as positive and equal individual differences. For example, due to no longer being able to walk, stand or weight bear, the person needed to use a wheelchair when moving around. This was described

as, "I am now confined to a wheelchair." The safest way for the person to eat and drink was via PEG tube. This was described disrespectfully as, "I am no longer to eat or drink as I am PEG-J fed", implying that by not being able to use their mouth, the person should not be considered as eating and drinking anymore.

●Staff did not always seek accessible ways to communicate with people. One person had pictorial aids, to help them engage and understand when communicating with staff. However, throughout the inspection these were not being used by staff supporting the person. Two staff were observed making infantile noises to encourage a person to eat, although the person was able to understand verbal communication prompts.

●Some people communicated using Makaton. Makaton is a language programme using signs and symbols to help people to communicate. Not all staff knew or were using Makaton when communicating with people who used this programme to encourage people's understanding and ability to be understood consistently by staff.

●People's preferences when deploying and scheduling staff were not always respected. One person had a recorded preference that their 1:1 support always be delivered by female staff. We observed the person being supported by male staff for periods during their 1:1 support time.

The provider had failed to ensure people were always treated with dignity and respect or having due regard to any relevant protected characteristics (as defined in section 149(7) of the Equality Act 2010) of service users. This is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Some staff we spoke with could explain how they communicated and engaged with people in accessible ways, such as via their own unique signs, gestures and vocalisations. The provider had started to offer more opportunities for staff to receive communication and Makaton training.

●We observed one person being supported 1:1 on one day of the inspection. Staff were patient and caring with the person and respected their choices throughout the day. People said staff responded in a timely and kind way if requesting support. One person said that if they asked for help, "Staff come very quickly, almost immediately."

●People told us their privacy was respected. One person said staff always knocked on their bedroom door before entering. A relative said, "If staff want to talk to me about [name] then they will do this in the privacy of their bedroom." There were data protection and record keeping polices in place to make sure that people's personal information was correctly stored, used and shared.

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

●People had support to access independent services to help them understand, answer questions and speak for them if necessary. People who lacked capacity had been supported to arrange referrals for independent mental capacity advocates (IMCA). IMCAs had then represented their wishes and feelings and helped involve them when decisions were being made about receiving medical treatment. Relatives had been supported by staff to be aware of external organisations that could offer advice and support to help make informed decisions about their family members care.

● Staff told us that they had time to listen to people, answer their questions and involve them in their support during shifts. A person said, "I feel listened to by staff here…nothing is too much trouble for them."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now remained the same.

This meant people's needs were not always met.

At the last inspection, the provider was not providing 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.

We identified specific concerns regarding lack of meaningful activities and opportunities for people to access the community. Care planning and review processes were not personalised or responsive to changes in people's individual needs.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

●People's strengths, levels of independence and quality of life was not always accounted for when planning and reviewing their care. Some people's care plans contained limited information about their personal history, individual likes and dislikes, interests, and how these informed their support needs and choices. Language and directions in care plans about people's support needs and choices was not always respectful or dignified. We have included examples of this in the 'Caring' and 'Effective' sections of this report.

● People, or relevant people such as relatives or healthcare professionals were not always supported to be involved in planning and reviewing their care. Planning and reviews of people's care by staff were not scheduled in advance and were not always formally recorded in order to ensure that any changes were followed up. A relative said, "Staff are not proactive at reviewing their care. They will respond once an issue arises."

● People had not always been supported to identify, or review, on-going individual aspirations and life goals. When people had been involved, their input into plans and reviews was not always documented. This increased the risk that people may not receive personalised support they needed and wanted.

●Care plans did not always record when people's support needs had changed. For example, changes to people's DoLS and PEG care support needs had not been updated in the care plans available for staff. This presented a risk that staff may not be aware or know how to deliver the support people needed. The risk was increased given the high number of agency staff who did not always know people well and did not always consistently work at the service.

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 service was not always meeting the communication needs of people with a disability or sensory loss. One person's care plan stated that they needed information about their care explained using easy read symbols, or pictures. However, they did not have easy read format information and pictures were not available or in use. Information relating to the running of the service, including how to recognise and report safeguarding concerns, was not available in easy read format for people who used this.

●People with communication aids were not always supported to use them as they required, meaning they may not always have as much choice and control as possible over their support.

●A speech and language therapist said they had received a recent referral to review a person's voice output communication aid (VOCA). They said, "Throughout my work with this person, it is very clear that they very, very, rarely had access to her VOCA…or it was never used with them at all. It was not regularly connected to their wheelchair, and often was not charged. They therefore relied on their low-tech communication book and staff interpreting their facial expressions. However, their communication book was also often not available, and they had to request it - something which I did not see them do very often."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

●People did not always have support to follow their interests and take part in appropriate social and cultural activities. People's 1:1 and group-based activity support did not always reflect their individual needs and choices. One person's records indicated that they liked music and entertainment, but their activity records did not show they had received support to access these events. People had activity records in place, but activity support staff did not use this information to monitor people's engagement or review what the purpose of the activity was and if this was being achieved. One relative said, "I would like them to do more activities they enjoy. I had to tell staff what they liked."

●People did not always have support to maintain or develop meaningful relationships. One person had DoLS condition that staff should ensure that arrangements were in place for them to regularly visit their family, but this had not been done. One person who had wished to develop a relationship and had identified sexuality needs had not been supported to formally plan how they could meet these needs or regularly review how well their support with this goal was working.

●People were not always able to access the wider community, to take part in meaningful activities and avoid social isolation. People and their relatives told us that there had been repeat issues with service transport not being available. One relative said, "This is an isolated place and transport is limited. My biggest problem with management is the transport issue." People's activity records did not demonstrate how people were supported to participate in activities outside of the service. When people had gone out, this was often as part of a group-based activity to maximise the available transport and did not reflect their preferred activity choices.

The provider was not ensuring people received person-centred care. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

●The deputy manager told us there were plans for a newly introduced keyworker role to take the lead from nurses in assessing, planning and reviewing people's care. This would help ensure these processes would be more personalised.

●Some people's care plans were available in accessible forms, such as easy read and pictures. Some people's care plans recorded how they wished to receive information non-verbally. During the inspection, we observed some staff who were aware and engaged with people using these methods.

●The activities assistant told us there were plans to work with the provider's 'Engagement' lead, to improve planning, delivery and evaluation of person-centred activities. A meeting was taking place during our inspection between people and the Engagement lead, where people were being asked for ideas and input into this process.

●Some relatives gave positive feedback about some of the activities people had been supported with, including concerts and going to see the nearest town's Christmas lights being switched on each year. One relative said, "I don't know if they are meaningful, but I feel they have enjoyed them." Another relative told us how their family member was supported to access an educational college each week for cooking, gardening and craft activities.

Improving care quality in response to complaints or concerns

●The provider had a complaints policy, and the deputy manager confirmed their approach to complaints was in line with this. The complaints policy was available for people in an accessible format. People who were able to, told us they felt comfortable to raise complaints and knew how to do this. One person said, "I would be able to raise concerns, I have done in the past about the service vehicles breaking down".

●Relatives were not always aware of the formal complaints policy but told us they knew who they could contact staff or more senior management if they needed to complain. Relatives who had done this said they had been responded to and had been satisfied with the outcome. A relative told us they were confident staff would speak up for people who were not able to and make a complaint on their behalf.

End of life care and support

●No one was receiving end of life care at the service at the time of the inspection. Each person had information about if they wanted to receive emergency resuscitation in the event of a medical emergency. The deputy manager had recently arranged an expected pathway with other healthcare services, so people would have access to necessary medical equipment and resources at the end of their lives.

●Not all people had detailed end of life care plans. The deputy manager was aware of the improvements that needed to be made in this area of practice. At the time of the inspection, a review to re-assess and comprehensively plan all people's end of life care needs was taking place. The review was identifying people's end of life care wishes, spiritual and cultural and emotional support needs.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same.

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

At the last inspection, the provider was failing to assess, monitor and improve the quality and safety of the services provided and maintain an accurate and cotemporaneous record in respect of each service user. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

●People remained at risk of receiving unsafe, poor quality or inadequate support. Although at this inspection we found that a breach of regulation 15 had been met, the provider continued to be in breach of seven of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included regulations 9, 10, 11, 12, 13, 17 and 18 in relation to: person centred care, dignity and respect, safe care and treatment, consent, safeguarding people from abuse, good governance and staffing.

●The risks and concerns found at this inspection have been highlighted in inspection reports about many of the provider's other services. This information had not led to similar risks to people at Horncastle Care Centre being reduced. The provider had failed to act upon known areas of concern, non-compliance and risk to improve the quality of care for people at Horncastle Care Centre.

●Systems and processes to assess, monitor and improve the quality and safety of the service were not operating effectively. Internal quality audit processes had not always identified risks and issues, or the actions needed to address them. This included issues regarding person-centred care, communication and safeguarding identified during this inspection. Since the last inspection, the provider had not always been aware of and had not been taking appropriate steps to prevent safeguarding issues before alerts had been raised externally.

●Service management and the provider's wider governance systems had not always ensured actions were taken to address any issues and risks in a timely manner. For example, internal quality audits in April 2018

recommended mental capacity and consent seeking processes and documents required improvement. This action was advised to be monitored and reviewed regularly and completed in three months. This had not been formally reviewed until December 2018. The action was reviewed again in June 2019 and was recorded as being in progress. The action remained incomplete at the time of this inspection.

● The provider had not ensured that staff at all levels understood their responsibilities and managed staff accountability effectively. Staff had not always met people's support needs or reported and acted in response to quality and safety issues. Staff continued to not always have the right, skills, knowledge or experience to manage risks and deliver safe, caring, responsive or effective care.

● A relative said, "Management isn't as supportive as they could have been for their team. (In reference to the previous CQC inspection); Why weren't staff told in more detail about what they should have been doing? I feel frustrated with senior management. They haven't supported staff at the service. Lessons should have been learnt earlier, they must have known what was wrong."

●The provider had not assessed, monitored and reduced risks relating to the health and safety of service users. Failure to manage constipation risks had caused a person harm. Failure to manage on-going choking and aspiration, skin integrity, mobility and postural support, epilepsy, medicines and behaviours that may challenge risks had exposed people to a consistently high risk of harm.

● People's care plans and risk assessments regarding DoLS, PEG, epilepsy, skin integrity, postural support, medicines, behaviours that may challenge, activities, end of life and social support needs were not always accurate, complete or up to date.

Working in partnership with others

●Staff had not always shared appropriate information with other agencies for the benefit of people. Concerns were raised by a GP regarding on-going information sharing issues with agency staff, meaning people did always not receive safe or effective support. When we requested information after the inspection in in relation to an allegation of abuse of service users living at Horncastle Care Centre, the provider had not included all documents that had been asked for or explained why they had not been sent.

●The provider had not always informed relevant partnership agencies such as the local authority safeguarding team about notable safety incidents. Safeguarding alerts had been raised by partnership agencies due to concerns that people were at risk of unsafe care due to varying and contradictory information being provided by staff during partnership agencies reviews of people's care.

●A health and social care professional said that when asking for specific information in response to a safeguarding concern, "I was often told I would receive it and I did not, or I received something which I had not asked for. I also requested to see it in person and was told staff were not allowed to show me documents without the approval of their manager, who was not present."

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

●A relative told us staff had not acted openly and seriously considered something had gone wrong when a safety incident had caused harm to their family member. They said, "There had been a problem with the hoisting, but they never mentioned this. When I raised I thought maybe a possible error with hoisting might

have caused the injury, staff just said they didn't think it was that. This could have been their immediate defensive reaction." The relative had continued to raise concerns and the incident was reviewed again, where the provider recognised there had been a mistake.

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

● Leadership at all levels at the service was not always visible and did not always inspire staff to provide a quality service. During the registered manager's extended absence there had been two managers who had both left after short periods. The most recent manager had been absent for an extended period.

●The service was currently being managed by the deputy manager and nominated individual (NI) on a part-time basis. When not managing the service, both the deputy manager and the NI confirmed they were currently expected to carry out the full responsibilities of their named job roles. For the deputy manager this included working shifts at the service as a nurse. The NI was also one of the provider's regional operations managers.

●Some staff told us the management changes had impacted on staff morale and it was not always easy to remain positive. Some staff said the nominated individual was not always approachable or available. They said if the deputy manager was not available they thought they should direct issues and ask for advice and support from head office. However, they were not confident about how to do this or who to speak with.

●Health and social care professionals feedback raised concerns the current management arrangements were inadequate and there was a lack of leadership and oversight at the service. A relative said, "I think the deputy manager is overworked and dealing with lots of issues."

●Staff had not always displayed values consistent with the provider's vision of service delivery. The provider's vision was that the highest quality care, based on the needs of the individual, was delivered by highly skilled professional teams. Following this inspection, the service has been in breach of multiple Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 over three consecutive inspections.

●This includes repeat breaches over an 18-month period in relation to failing to provide skilled, knowledgeable and trained staff, manage risks, keep people safe from abuse and improper treatment and ensure good governance. There have been repeat breaches over a 5-month period in relation to providing person-centred care, treating people with respect and dignity and seeking people's consent in line with legislation.

●The imposition of provider level conditions had not been effective in driving improvement or preventing repeat themes of concern re-occurring in relation to people's safety, quality of care and staffing at Horncastle Care Centre.

The provider had failed to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved. The service had not always worked in partnership effectively with other agencies and was not always open and transparent with service users and other relevant persons. This was a continued breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●CQC registration requirements had not always been met. The registered manager had been absent from managing a regulated activity at the service for several months. It is a legal requirement that the provider notify CQC if a registered manager is absent for more than 28 continuous days. This had not been done.

The provider had failed to notify the CQC of an absence of a registered manager from managing the regulated activity at the service for a continuous period of 28 days of more. This was a breach of Regulation 14 (Notice of absence) of the Care Quality Commission (Registration) Regulations 2009.

●The deputy manager told us they were promoting an open working environment and person-centred ways of working with the staff team. They said, "This is a big culture change about how staff interact with people." One staff said since the last inspection work on improving the culture at the service had been taking place. They said, "We have had a lot of changes and learn new things."

●People said they liked the deputy manager. Staff said the deputy manager was approachable and visible and gave them constructive information, advice and guidance about their responsibilities and performance. Staff said they felt permanent members of the team were working hard to stay positive and support each other.

●Other relatives told us the provider had shared information openly and transparently about their family members care, including when there had been safety incidents. One person we spoke with said they felt there was a shared commitment amongst permanent staff to provide caring support. They said, "Some staff have been here for up to 10 years. They work hard and I think they genuinely care about the residents."

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

●People's views and experiences were gathered to help improve the service. People and relatives were sent questionnaires to ask for their views on what was and was not working at the service and. Questionnaires were available in an accessible format.

●There were meetings for people who used the service each month to gain their ideas and choices about their activities and menu options. The provider had recently arranged more regular relative meetings to discuss and gain their feedback about service performance issues.

●Staff had opportunities to be involved in developing the service. There were formal staff meetings at least every three months. There were regular meetings to discuss different ways to meet people's individual care needs, when required. One staff said there had been a change since the last inspection and these discussions now included more consideration about ensuring person-centred support when providing care for people.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 was not ensuring people received person-centred care.

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

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 people were always treated with dignity and respect or having due regard to any relevant protected characteristics (as defined in section 149(7) of the Equality Act 2010) of service users.

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

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 service users consent to care and treatment had been sought in accordance with legislation.

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users, ensure safe and proper use of medicines and thoroughly review, investigate, monitor and act to make improvements in relation to incidents that affect the health safety and welfare of service users.

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

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 failed to ensure systems and processes protected people from abuse and improper treatment.

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

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 had failed to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved. The service had not always worked in partnership effectively with other agencies and was not always open and transparent with service users and other relevant persons.

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care

Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

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 had failed to ensure staff had received appropriate support, training and personal development and evidence, or that the service had assured themselves of their competence to carry out the duties they are employed to perform.

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.