Eleanor Nursing and Social Care Limited

Pine Lodge Care Home

Inspection report

26-32
Key Street
Sittingbourne
ME10 1YU

Date of inspection visit:
11 July 2023
12 July 2023

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21 August 2023

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
Pine Lodge Care Home is a residential care home providing accommodation and personal care to up to 59 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 58 people using the service.

People's experience of using this service and what we found
Although people and their relatives told us the service was safe and they were well cared for, we found risks to people had not been managed. The provider and registered manager lacked oversight and had not acted to understand the quality of the service and make improvements. They had not developed a culture where people received care personalised to their individual needs and their views and experiences were understood and used to develop the service.

Potential safeguarding concerns had not been shared with the local authority safeguarding team so they could be investigated. People's medicines were not managed safely and they had not always received their medicines as prescribed. People were not offered food that met their health needs. Staff had not always shared sufficient information with health care professionals for people's health needs to be understood.

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

Any equality needs were not identified and understood. People had not been given the opportunity to discuss their end of life plans and wishes. Information was not accessible to people in ways they understood. People's needs had not been assessed before they moved into the service. They had not been informed of the use of CCTV and their consent to its use had not been obtained.

Staff had not been recruited safely and received the training and support they needed to fulfil their roles. Records were not accurate or complete. Guidance had not been provided to staff about how to meet people's individual needs. Lessons had not been learnt when things had gone wrong and people and their relatives had not always received an apology.

The environment had not been planned and decorated to support people to be as independent as possible. People were protected from the risk of infection.

Staff were kind and caring. People and their relatives were confident to raise any complaints with the management team.

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 6 January 2022 and this is the first inspection. The last rating for the service under the previous provider was Good, published on 21 July 2017.

Why we inspected
The inspection was prompted in part due to concerns received about access to health care, diabetes management, inaccurate records, staff training and support, medicines management and ineffective checks and audits. A decision was made for us to inspect and examine those risks.

Enforcement and Recommendations
We have identified breaches in relation to staff recruitment and training, oversight and continuous improvement, records, obtaining and acting on feedback, mitigating risks in relation to people's safety, medicines and diet, obtaining consent, assessments, privacy and treating people with dignity at this inspection.

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

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Pine Lodge Care Home

Detailed findings

Background to this inspection

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

Inspection team
This inspection was completed by 2 inspectors, a specialist professional 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.

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

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

At the time of our inspection there was a registered manager in post. However, they did not take part in the inspection as they were on leave.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since they were registered. We sought feedback from the local authority who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who lived at the service and 11 relatives about their experience of the care provided. We spoke with 9 staff including the operations manager, deputy manager, team leaders, care staff and chef. We spent time observing interactions between staff and people in communal areas. We reviewed a range of records including 14 people's care records including medicines records. We looked at 6 staff recruitment records and a variety of records relating to the management of the service including meeting minutes and audits.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of 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

- People were not protected from the risk of abuse or restrictions. An allegation of abuse was being investigated by the local authority safeguarding team at the time of our inspection.
- Three incidents had not been reported to the local authority safeguarding team for consideration. These included a fall resulting in a serious injury and a wound. People were at risk of continued harm because incidents had not been analysed to understand what had gone wrong and how they could be prevented from occurring again.
- Action had not been taken to investigate an incident between 2 people. It had not been reported to the local authority for their investigation and support and there was a risk it could occur again.
- An alert mat was fitted in each person's bedroom to inform staff when people were moving around. The need to have mats in place, such as to manage the risk of falls, had not been assessed and the management team had not considered this was a restriction on people's ability to move around freely.

The provider and registered manager had failed to operate effective systems and processes to prevent abuse of service users and investigate any allegation or evidence of abuse. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People were not protected against the risk of harm. Individualised detailed guidance had not been provided to staff about how to mitigate risks and provide safe care. Staff told us information in people's care plans did not give them the guidance they needed to keep people safe and they relied on their experience and the information shared by colleagues. There was a risk care would not be safe and consistent .
- Individual risks in relation to diabetes had not been assessed and mitigated. Personalised guidance had not been provided to staff about how to identify if people were at risk of becoming unwell and the action to take. For example, the usual blood glucose range for each person and what to do if their blood glucose went outside of this range was not included.
- People were not protected from the risk of developing pressure ulcers. Some people used special air flow mattresses to reduce the risks, however these had not been set correctly. For example, we found a person with pressure ulcers using a mattress which was set too firmly. This increased the risk of the wounds not healing as the equipment was not being used to its full potential. No processes were in operation to check mattresses were set and working correctly. The management team put these in place after our inspection.
- Some people required a catheter to drain urine from their bladder. Staff were required to support people with catheter care in different ways depending on the type of catheter they had. People's care plans recognised they required a catheter; however, detailed guidance had not been provided about its care. There was no guidance about the signs if the person had an infection, if the catheter site was infected or if

the catheter was blocked and what action they should take. Following our inspection, the registered manager sent us updated risk assessments which contained more guidance.
● Action had not been taken to keep people safe in the event of an emergency. Personal emergency evacuations plans (PEEP) were not in place for each person. PEEPs are information about the assistance people require to escape to a place of safety and are used by staff and emergency professionals to evacuate people quickly and safely. In February 2023 Kent Fire & Rescue Service required the provider make their fire alarm system addressable to show the detector or device activated. This had not been done and the management team did not know this was a requirement.

The provider and registered manager had failed to do all that was reasonably practicable to assess and mitigate risks to people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff had not been recruited safely. Robust checks had not been completed to ensure staff were of good character and had the skills and experience required for their role.
● Disclosure and Barring Service (DBS) checks had not consistently been obtained before staff began to work at the service. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. One staff member was working without a DBS check in place. The necessity for this had not been assessed and action had not been taken to mitigate risks to people. The management team completed this during our inspection.
● Risk assessments had not been completed when staff had disclosures on the DBS. These are required to understand any potential risks to people and agree any strategies to manage these risks. This left people at risk of harm.

The provider and registered manager had failed to operate effective recruitment procedures to ensure all staff were of good character. This was a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff to meet people's needs. We observed staff responding promptly to people's requests for assistance. People told us staff can promptly when they used their call bell. Relatives told us there were enough staff, one relative commented, "There is always plenty of staff around"

Using medicines safely; Learning lessons when things go wrong
● People's medicines were not managed safely. Effective processes were not in operation to order, administer and store medicines. Some people had not received their medicines correctly in May 2023 as they had not been ordered in time for them to be received before people needed them.
● Medicines administration records (MAR) completed by staff did not always contain detailed guidance for staff about safe administration. For example, one person was prescribed a medicine which the manufacturer advised should have been taken on an empty stomach. This was not included on the MAR and the medicine had been given with another medicine. There was a risk the medicine would not be effective.
● Risks associated with medicines had not been assessed and action had not been taken to mitigate them. For example, some people who smoked also used emollient creams to help manage dry skin conditions. Emollients easily transfer from skin to clothing, bedding and towels. When fabric with dried-on emollient comes into contact with a naked flame, the resulting fire burns quickly and intensely. This left people at risk of injury.
● Effective systems were not in operation to ensure MARs were accurate. Hand written entries had not been

signed and checked by 2 staff to make sure they were accurate. On occasions staff forgot to sign the MAR to confirm people had received their medicines. It was practice at the service for staff to go back and sign the records when gaps had been identified. This may be several days after the medicine should have been administered. The provider could not be assured staff would accurately remember administering the medicine they were signing to confirm they had given.

● Medicines are not consistently administered at the times recorded on the MAR. For example, MAR showed one person should take their medicines at 10:00pm. However, at times this was signed as being given by staff who finished their shift at 9:00pm. Staff confirmed they had given the medicine before they had left at 9:00pm. A side effect of the medicine was possible dizziness and there was a risk taking the medicine before they went to bed may put the person at risk of falling. Other medicines were being administered at 5:00pm rather than at night as prescribed.

● Effective systems were not in operation to investigate and analyse medicines errors and incidents, and there was a risk they would occur again. For example, in May 2023, 4 people had gone without one of their medicines for between 4 and 14 days because the medicines were out of stock. Action had not been taken to prevent this happening again and people were at risk of becoming unwell.

● Two people had not received their insulin as prescribed in May and June 2023. Insulin is a medicine which helps the body use sugar for energy. Insulin reduces the chances of people getting the symptoms of high blood sugar and serious long-term health problems. No action had been taken to investigate these incidents and keep the people safe and well in the future.

The provider and registered manager had failed to ensure the proper and safe management of medicines and people were at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

There were no restrictions on people receiving visitors. A relative told us, "I am not restricted to visiting times". We observed people spending time with their relatives.

Inadequate

Is the service effective?

Our findings

Our findings - Is the service effective? = Inadequate

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

- Assessments of people's needs had not been completed with people and those who knew them well before they began to use the service. The management team relied on information provided by health and social care professionals to decide if they could meet people's needs. There was a risk staff would not have the skills or information they required to meet people's needs.
- People and their relatives had not been asked to share information about their lives before they moved into the service to help staff get to know them. This included information about any protected characteristics under the Equality Act, such as race and gender.
- Staff had not ensured they had up to date information about people's medicines from their GP or the hospital before they moved in. They administered the medicines people brought with them without checking the medicine was still prescribed, the correct dose or if any medicines were missing. This left people at risk of harm.
- Following our inspection the registered manager told us, 'All new residents will be booked for an initial face to face assessment before admission'.

The provider and registered manager had failed to carry out, collaboratively with the relevant person, an assessment of each service user's needs and preferences. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- People were not cared for by staff who had the skills to meet their needs. Medicines competency assessments had been completed. However, when medicines incidents had occurred, action had not been taken to support staff develop their skills. This left people at risk of not receiving their medicines when they needed them.
- New staff had not completed a robust induction when they began working at the service to ensure they could fulfil their role. A staff member told us they had been shown around the building and had shadowed other staff. Their competency to care for people had not been assessed. They did not have a recognised social care qualification and had not been supported to complete the care certificate. This is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
- The management team used a training matrix to track when staff completed training. This showed 19 out

of 54 staff were not 100% compliant with the required training and 6 of these had not completed any training. There was a risk staff would not have the skills and competence to fulfil their role. Face to face training such as moving and handling training was not recorded on the matrix which made it harder to track.
● Staff had not met regularly with a member of the management team to discuss their practice and development needs. Following our inspection the registered manager told us '40 out of 60 staff have received supervisions'. However, records they provided showed only 11 out of 57 staff had received supervision in 2023. Gaps in some staff's knowledge and skills had not been identified and staff had not been supported to develop in their role. Training goals had been set for a staff member in January 2023 but these had not been reviewed to ensure the staff member now had the skills required. This left people at risk of not receiving the care they needed.

The provider and registered manager had failed to provide staff with appropriate support, training, supervision and appraisal necessary to carry out their duties. This was a breach of regulation 18(1) 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 not always offered food which met their needs and some people told us they did not like the food at the service. Others were happy with the food offered.
● Six people were prescribed food supplements as they were at risk of losing weight. Their care had not been planned in line with the local health trust 'Food first for care homes' guidance and information had not been shared with kitchen staff about the people's need for high calorie, high protein diets. This left people relying on food supplements rather than receiving food to meet their nutritional needs.
● People living with diabetes were not offered a diet low in sugar. Kitchen staff told us all meals were prepared with sugar alternatives. However, we found people with diabetes were not always offered low sugar foods and these were not held in stock. The cook told us they prepared bread pudding as an alternative for diabetics at times. Bread pudding contains high levels of sugar and carbohydrates which should be limited for diabetics.
● Night staff completed people's food intake records the night before food was offered based on the menu options. Day staff told us they amended them to reflect what people had eaten. However, the provider could not be assured the records were accurate as they were time stamped at approximately midnight the day before. It is important these records are accurate as staff and health care professionals use them when making decisions about people's care.

The provider and registered manager had failed to do all that was reasonably practicable to mitigate risks related to people's diets. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People's right to make informed decisions or have others lawfully make decisions on their behalf had not been upheld. Staff did not understand the principles of the MCA. The management team told us some people had appointed people to make decisions on their behalf when they were no longer able. Copies of authorisations had not been obtained to ensure the correct people were always involved in making decisions and had the lawful authority to do so.
● Applications for DoLS had been made appropriately. However, the conditions on DoLS had not been consistently compiled with. Capacity assessments and best interest decisions had not been completed as the conditions required.
● Decisions people made were not kept under review. Fourteen people using the service shared their bedroom with another person. Records of people's consent or decisions made in their best interest had not been maintained and decisions had not been kept under review. Following a visit from the local authority a week before our inspection, staff had asked people if they continued to be happy to share and 1 person said they were not. Not keeping decisions under review prevented people from making new decisions and having them acted on.
● The service had an unrestricted social media page which contained a large number of photographs of people. People had not been informed photographs of them were accessible to anyone who wished to view them. Assessments of people's ability to consent had not been completed and decisions had not been made in their best interests. There was a risk people would not have the privacy they wanted.
● People had not been consulted about the installation of CCTV in communal areas of the service. People's consent to be filmed had not been obtained and they had not been told how this would be managed. New people using the service were not told about the CCTV so they could make an informed decision before they moved in.

The provider and registered manager had failed to obtain consent to care and treatment. Where people were unable to give such consent because they lacked capacity to do so, the principles of the Mental Capacity Act had not been complied with. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Staff did not always work with health care professionals to ensure people received the treatment they needed. Relatives told us they were informed about any changes in their loved one's health.
● People's oral healthcare plans were not specific to their individual needs. For example, one person needed support to brush their teeth in the early evening as they were often too tired when they went to bed. This was not included in their records to ensure they consistently received the support they needed.
● Oral health assessments had been completed. For one person it was noted in the 2020, 2021, 2022 and 2023 assessments that the person needed to be seen by a dentist. No action had been taken and the person had not been referred to a dentist. Staff told us the person was not in pain and did not need to see a dentist. However, the management team had identified a referral had been outstanding for four years and no action had been taken to look into this meaning there was a risk people would be at prolonged risk of harm.
● A frailty advanced clinical practitioner visited weekly to assess anyone who was unwell, deteriorating or required medical input. They also completed annual reviews for dementia, long term conditions and do not attempt cardiopulmonary resuscitation decisions.
● Staff contacted health care professionals between these visits if people required treatment. However, a health care professional told us staff did not always provide the detailed information they needed to triage

people's needs and make decisions on the urgency for treatment. Following our inspection, a meeting was planned with the frailty advanced clinical practitioner to look at ways of improving staff's communication.

The provider and registered manager had failed to carry out, collaboratively with the relevant person, an assessment of each service user's needs and preferences. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The building had been adapted to meet most people's physical needs. However, work was required to support people living with dementia to move around without support.

● The provider had redecorated some areas of the building and plans were in place to redecorate other areas. They had not considered best practice in dementia friendly environments, such as clear lighting. Some areas of the building were not clearly lit to support people to identify rooms, equipment and signs and move around freely.

● Some people had their name on their bedroom door, however others did not. Names and room numbers were placed high on the door and may be above people's line of sight. Action had not been taken to support people to identify their bedroom and other rooms in the service with a clearly written sign and a picture the person would identify with. During our inspection people knocked on the office door several times asking where the toilet was.

● The maintenance team had taken action when they could to improve people's bedroom environment. A person told us, "They always try to change things to help me live comfortably. For instance, the light was a little dim in my bedroom and I have bad eyesight so the maintenance man came and put another light in so it was brighter, it's so much better now."

● People's bedrooms were personalised and they were encouraged to make them homely. A relative told us, "When our loved one moved to the home, we were encouraged to make the room as homely as we wanted, we hung pictures on the wall".

We recommend the provider refer to national best practice guidance when planning signage, the decoration and other adaptations to the premises to help meet people's needs and promote their independence.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- The management team had not ensured people's dignity was always promoted. For example, we observed 2 people wearing open back hospital gowns. A member of the management team told us this was because the people struggled with pyjamas. No alternatives to hospital gowns had been considered to ensure people's dignity was always maintained.
- An audit by an outside consultant had identified continence products being used to protect chair seats. These were being used during our inspection and did not provide people with dignified care.
- People did not always have privacy. Medicines packaging containing people's name and other personal information was disposed of in the general waste rather than confidential waste. There was a risk information about their health would not remain confidential.
- New people were not advised there was CCTV in operation in communal areas of the building before they moved it. They were not enabled to make an informed decision about this loss of privacy before began using the service.

The provider and registered manager had failed to ensure service users were treated with dignity and respect and had privacy. This was a breach of regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
- People had not had opportunities to chat about their lifestyle choices, sexual orientation and gender identity. There was a risk their preferences would not be respected.
- We observed staff treating people with kindness and compassion and respecting their wishes and preferences. Relatives told us, "The staff are lovely polite and kind always find time to chat and make me and my family feel welcome when we visit" and, "I feel the staff genuinely care about the residents and go out of their way to make residents comfortable".
- People and staff were relaxed in each other's company and enjoyed chatting together. We observed people and staff laughing together.
- Staff spoke with people and referred to them respectfully. They described people in positive ways. Staff referred to people by their preferred names and supported inspectors to do this when they were chatting to people.

Supporting people to express their views and be involved in making decisions about their care
- Choices people made were respected. For example, some people preferred to spend their time in their

bedroom watching television. Staff respected people's decision. A relative told us, "My loved one prefers to be on their own. The staff do encourage them to join in with the entertainment but they have always preferred their own company. They prefer to eat and drink in their own room and the staff respect this".

● People who needed support to share their views were supported by their families or paid advocates. Staff knew people's advocates and advocacy organisations, and how to contact them when needed.

Requires Improvement

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 requires improvement. This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Information was not accessible to people in ways they understood. Important information such as the complaints process was not available in other languages or in pictorial form.
- Information that people may wish to refer to, such as the menu for the day, was not available. People had to rely on asking staff and being told the information.

The provider and registered manager had failed to provide information to service users in ways that meet their needs and preferences. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
- Staff knew people and spent time with them chatting about things they enjoyed. However, guidance was not in place to support staff to consistently provide care in the way people wished.
- Staff relied on information shared with them by people, their relatives and other staff to get to know people. Some people had told managers about areas of their life but this information was not available to staff. Staff told us this information was helpful when distracting people from any embarrassment when they were receiving personal care. A relative told us, "My loved one enjoys training the staff. They are very good and make sure things are done in the way my loved one wants. Staff are very aware and respect my loved one and strive to keep them as independent as they can".
- Information was not available to staff about people's preferences. Staff told us one person liked their support provided in a very particular way to avoid discomfort. This information was not included in the person's records and there was a risk they would not consistently receive care as they preferred. This is an area for improvement.

End of life care and support
- People and their relatives had not consistently been given the opportunity to discuss their end of life preferences. A relative told us, "The home instigated an end of life care meeting where I was openly able to discuss my loved one's wishes". However, other people had not been given the same opportunities.

● Important information such as where people wished to be, who they wished to be with them, decisions about treatment they did not wish to receive and their cultural or spiritual preferences were not known.
● A relative told us, shortly before our inspection, their loved one had decided they do not wish to be admitted into hospital again.
● People who wanted, were supported to remain at the service at the end of their life by community nurses. Pain relief and other end of life medicines were held at the service and community nurses administered these when they were required.

We recommend the provider refers to national guidance in relation to supporting people to talk about their end of life wishes and preferences.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People were not consistently supported to take part in pastimes and occupations they enjoyed. An activities staff member was in post and we observed people enjoying the activities they offered, such as singing. However, people were not offered activities or supported to take part in day to day tasks when they were not working.
● The registered manager told us, 'Residents are given one to one time as the care staff will assist residents with a bath or shower and complete nail care, also female residents will have their nails painted and some residents will have their hair braided'. This was part of people's care and did not provide them with meaningful occupation and stimulation.
● People were not supported to continue to complete day to day tasks such as preparing simple meals and drinks, and managing their personal items. This reduced people's independence. We observed the television was on but people did not appear to be watching it. Staff had not reviewed television listings and told people about programmes which may interest them.
● People who chose to spend time in their bedroom told us they were informed what activities were on offer each day and given the opportunity to join in. They told us, "[staff members name] pops in, tells me what is happening on the day and asks if I would like to go down to join" and "I don't really like going down to the lounge. I tried it but prefer to be in my room. The girl who does the 'entertainment' comes and tells me what is going on and asks if I want to join. I did join the trip the other day though. Got out and that was lovely. A really good day".

We recommend the provider refers to national guidance when planning supported for people to follow their interests and take part in activities that are socially and culturally relevant and appropriate to them.

Improving care quality in response to complaints or concerns
● People and their relatives were confident to raise any concerns they had. Their comments included, "Everything is ok here at the moment. I know I must complain if they are not, as it wont get changed. I would talk to the staff or the manager", "The management are approachable and listen. I have not had the need to complain" and "If we had any concerns we all feel confident in speaking to either the manager or deputy manager and feel we would be listened to".
● A process was in place to receive, investigate and respond to complaints. Complaints received had been investigated and responses had been made to the complainant.

Inadequate

Is the service well-led?

Our findings

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

This is the first inspection for 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.

Continuous learning and improving care

- The provider and registered manager's oversight of the service was inadequate. Despite some audits being carried out, these had not brought about the changes necessary to ensure people received a service which was safe or met their needs.
- The provider had an 'independent quality assurance system is in place'. However their visits had not been used to drive improvements. Their latest action plan dated April 2023 showed shortfalls continued, including no fire evacuation practice and the need for end of life care plans. Despite these being identified in January 2023, the provider and registered manager had not acted and the risks to people continued.
- The provider and registered manager had failed to identify the other shortfalls we found during our inspection. These included poor risk management, people not receiving the food they needed to keep them well and a lack of staff training and development. There was a risk these shortfalls would continue and have a negative impact on people's health and welfare.
- The registered manager had delegated checks to other staff but had not checked these were done correctly and actions where taken to address any shortfalls. Medication audits were completed by a senior carer. Action had not been taken to address the shortfalls found in medicines practice and these continued. A staff file audit had failed to identify the shortfalls in recruitment practices we found.
- The registered manager and staff told us the electronic care planning system at the service did not support them to write person centred guidance and include important information about peoples' needs and preferences. Despite this being an on going concern, no action was taken until our inspection to address this.

The provider and registered manager had failed to assess, monitor and improve the quality and safety of the service and mitigate the risks relating to the health, safety and welfare of service users. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had failed to achieve their goal to 'promote independence and understand that all of our residents should be treated as individuals so every person living with us has a plan of care designed around their requirements and preferences, granting them choice in all aspects of their daily routine'.
- We found a culture where staff did what they thought was best without considering best practice and people's wishes. People were not supported to consistently maintained their independence and plan all

areas of their care.
● Policies and procedures were in place but were not always followed. For example, people and their representatives have not been consulted about the use of CCTV and hand written entries on MARs had not been checked for accuracy. The management team did not know who the provider's governance lead was to discuss any issues with.
● People and their relatives have not received an apology when medicines had not been administered as prescribed. Apologies had been made in response to formal complaints.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● There was a lack of structure within the leadership team. No rationale was in place to demonstrate why staff had been delegated specific roles and responsibilities. For example, the medicines lead had not completed additional training around the management of medicines. Staff responsible for writing and reviewing people's care plans and risk assessments did not have additional skills and training in their area.
● The registered manager had been in post since November 2022. They were supported by a deputy manager, operations manager and 2 heads of care. The registered manager was not present during our inspection. The deputy manager and operations manager were unable to answer some of our questions. Robust systems were not in place to ensure the provider had access to important information at all times.
● Effective systems were not in operation to understand what action the manager was taking to improve the service, review the registered managers practice and support them with any developments in their role. The operations manager was unable to tell us why actions had not been completed and when they expected them to be complete.

The provider and registered manager had failed to monitor and improve the quality of the service by keeping the culture under constant review. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Records of people's care were not always completed contemporaneously. Staff often had to wait to complete records as they only had access to one computer to do this. Other records such as MARs were not complete and contained gaps.
● Care plans were not accurate around people's needs and preferences and did not offer staff with the guidance they needed to provide safe care and treatment. The management team told us important information such as the outcomes of contact with health care professionals was not easy to find and this made it difficult for them to have oversight of people's changing needs.

The provider and registered manager had failed to maintain securely an accurate and contemporaneous record in respect of each service user, including a record of the care provided to the service user. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and staff had been asked for their views of the service but these had not been used to make improvements.
● People had been asked for their views at the beginning of 2023 and had completed questionnaires with staff. Questions included people's views of staff; however the provider and registered manager had not considered if people's responses may be hindered by having staff present. No analysis of the survey had been completed and people had not received feedback about the outcome and any improvements being made.

● The provider had sent out a survey to staff in October 2022 and 4 staff had responded. Staff feedback included, 'Lack of support from management, Bullies, Lack of staff and the work load is hard because of it, selfish and lazy people' and 'The way staff treat each other no respect for one another'. Again, no analysis had been completed and feedback had not been shared. No further surveys had been completed to understand if the culture at the service had improved.
● Feedback had not been requested from visiting professionals and people's relatives, to understand their experience of the service.

The provider and registered manager had failed to seek and act on feedback from service users, relatives, staff and other stakeholders with a view to improving the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● The registered manager and provider had not worked with other partners to improve the service until shortly before our inspection. They had begun to work with the local authority commissioner and safeguarding team to understand best practice and improve the service.
● Following our inspection, they contacted health care professionals including the GP surgery to agree ways of working that would improve people's care.