Crocus Care Ltd

Lorna House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
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

Lorna House is a residential care home providing personal care to up to 24 people. At the time of our inspection there were 17 people using the service. Accommodation is over two floors of a large period property with bedrooms on the first floor serviced by a stair lift. Most bedrooms have en-suite facilities. There is a large communal lounge, a dining room, conservatory and pleasant, well-maintained gardens.

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

Risks to peoples' safety were not assessed or monitored effectively and were not well managed. There had been a significant number of unwitnessed falls in the twelve months prior to our inspection. Accident records were not reviewed, and not enough action was taken to minimise the risk of falls. Other risks to peoples' safety, such as choking, had either not been identified or were not well managed. One person, who was living with dementia, had a known risk of leaving the service alone when it was not considered safe to do so, no action had been taken to mitigate the risk. Staff did not always support people to access healthcare services in a timely way.

Care plans did not contain any information to guide staff as to how to support people to manage specific medical conditions, such as diabetes and Parkinson's Disease, safely. Fire safety records were not kept up to date.

Peoples' medicines were not managed safely. There were no systems in place to monitor stock control and the amount of medicines received were not recorded. No medicines audits were being completed. Systems were not always operated effectively to ensure staff were recruited safely and the risk of the spread of infection was not well managed. No notifications of abuse or neglect had been made by the service since our last inspection, however, four safeguarding alerts had been made by health professionals in the past twelve months.

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 good practice.

People's care was not always delivered or continually assessed in line with their desired outcomes. People's family members told us they were not involved in reviews of people's care.

Most staff had completed training in the areas the service identified as mandatory, such as safeguarding and moving and handling. However, the service had not identified that staff required training around individual health needs and conditions, such as dysphagia, diabetes or the management of Parkinson's Disease.

People's privacy and dignity was not always respected. People were not always supported to be independent and we saw people trying to stand up and move being repeatedly asked to sit back down rather than supported to mobilise where they wanted to be. Three people did not have any care plans in place. Care plans that were in place were very brief, basic and task orientated, and had not been regularly reviewed or updated to reflect people's changing needs. Staff told us there were some routines in place that appeared to suit the staff, rather than people. There was limited support for people to avoid social isolation, follow interests and take part in activities.

There were no systems or processes in place to ensure the service was well led. The service had failed to identify and act on risk and had failed to provide a service that met people's individual needs and preferences. There were no systems in place to audit medicines, incidents, accidents, care plans or complaints to identify themes and trends. The provider did not have any quality oversight systems in place. Notifications were not always made in line with legal requirements.

People and their families were not involved in their care planning and there were no systems in place to seek feedback from people using the service. Staff told us they did not feel supported, and felt morale was "very low". One staff member told us, "I love working here, but you dread coming to work because you don't know what it's going to be like."

People told us they enjoyed the food and were offered choices. We observed people enjoying a meal on the first day of our inspection. One person told us it was, "Very nice."

People were well dressed. One person's family member said their loved one, "Always looks well, clean, tidy and shaven." We saw warm relationships between staff and people, and people and their families told us they felt the staff were caring. One person told us the staff were "wonderful" and another said, "They're very kind, and jolly, I'm happy here." Comments from people's families included, "Staff are caring", "Immensely kind" and, "The girls are really nice." Some staff had worked at the service for many years and knew people well.

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

Rating at last inspection

The last rating for this service was good (published 24 January 2018).

At our last inspection we found there were no protocols in place to guide staff when it was appropriate to use 'when required' medicines, which is good practice. We discussed this with the registered manager who said they would discuss implementing them with the pharmacist. At this inspection we found that this had not been done and there were still no protocols in place.

At our last inspection we recommended the service consider how information could be made available to people to support assisted communication where they may benefit from this. At this inspection we found no progress had been made.

Why we inspected

We undertook this inspection as part of a random selection of services rated Good and Outstanding. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the

service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

The registered manager was not available at the time of our inspection. The provider responded immediately and put an acting manager in place in the registered managers absence. The acting manager took immediate action to mitigate the risks identified and worked openly with CQC and the Local Authority to ensure the most urgent concerns were addressed. This included modifying two peoples' diets, providing clear information for staff, removing some equipment, putting other equipment in place and asking the district nursing team to administer one person's insulin.

Enforcement and Recommendations

We have identified breaches in relation to safe care and treatment, person-centred care, need for consent, fit and proper persons employed, notification of incidents and good governance at this inspection.

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

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work with the 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	**Inadequate**
Is the service effective? The service was not always effective	**Requires Improvement**
Is the service caring? People's privacy and dignity was not always respected.	**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**

Lorna House

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.

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

Inspection team
The inspection was carried out by one inspector and one assistant inspector.

Service and service type
Lorna House 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. Lorna House 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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 our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 13 April 2022 and ended on 27 April 2022. We visited the location's service on 13 April 2022 and 21 April 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. 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 reviewed a range of records including eleven people's care records, accident records, handover records and medicine administration charts. We reviewed four staff recruitment files. We spoke with 12 members of staff including the acting manager, care staff and domestic staff. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with nine people's family members. We spent time speaking with and observing the care of most of the people living at the service over the course of our site visits and observed lunch on day one. We sought and received feedback from the Local Authority quality improvement team.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. 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

- Risks to peoples' safety were not assessed or monitored effectively and were not well managed.
- Three people had no risk assessments in place.
- Risk assessments that were in place had not been reviewed since January 2022. This meant where people's needs had changed their level of risk had not been assessed accordingly.
- There had been a significant number of unwitnessed falls in the twelve months prior to our inspection. Whilst falls were reported to the local authority, accident records were not reviewed, and not enough action was taken to minimise the risk of falls.
- Staff had made efforts to modify one person's diet, however they did not have the training or knowledge to do so in line with best practice and had not followed up a request for professional input made some months previously. We observed a second person to be struggling to swallow during the first day of our site visit. A staff member told us they usually did this "when they eat and drink." Staff had not identified they may have an impaired swallow which could put them at risk of choking and had not sought professional guidance.
- People were living with medical conditions including diabetes, Parkinson's and epilepsy. One person suffered from recurrent urinary tract infections and another used oxygen. There were no care plans in place to guide staff as to how to support people to manage these conditions safely.
- One person, who was living with dementia, had a known risk of leaving the service alone when it was not considered safe to do so. On the morning of the second day of our inspection the person had been found on the driveway attempting to go to the shops. Staff told us this had happened before, however previous incidents had not been recorded and no action had been taken to mitigate the risk.
- Handover records were not sufficiently detailed to ensure staff were able to monitor people's health. For example, one person's records said they were in bed after a fall but failed to report they had sustained an injury or sought medical advice.
- Fire safety records were not kept up to date. The evacuation list had incorrect entries, which put people at risk in the event of an evacuation.
- Following the first day of our inspection we raised three safeguarding alerts with the local authority which had not been identified by staff.

The service did not assess, monitor or mitigate the risks to peoples' safety. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- The registered manager was not available at the time of our inspection. The provider responded immediately and put an acting manager in place in the registered managers absence.
- The acting manager took immediate action to mitigate the risks identified and worked openly with CQC

and the local authority to ensure the most urgent concerns were addressed. This included modifying two peoples' diets, providing clear information for staff, removing some equipment and putting other equipment in place.
●A maintenance person was employed, and they completed regular fire tests and completed remedial works where required.
●Contracts were in place to ensure equipment was routinely serviced.

Using medicines safely

At our last inspection in 2017, we found there were no protocols in place to guide staff when it was appropriate to use 'when required' medicines, which is good practice. We discussed this with the registered manager who said they would discuss implementing them with the pharmacist. At this inspection we found that this had not been done and there were still no protocols in place.

●Peoples' medicines were not managed safely.
●There were no systems in place to monitor stock control and the amount of medicines received were not recorded.
●Medicines administration records were not always fully completed, and where there were gaps, no explanation as to why the person missed their medicine was recorded.
●There were no protocols in place in relation to 'when required' medicines, for example pain relief.
●Whilst staff had completed medicines training, no competency assessments regarding administration of medicines had been completed.
●Some specific competency assessments had been completed by healthcare professionals in relation to the administration of insulin, however these had not been reviewed in the previous twelve months, in line with best practice.
●Administration times of time sensitive medicines, such as Parkinson's medicines and antibiotics, were not always recorded in line with best practice.
●One person had recently had an adverse reaction to prescribed medicine, however, their care plan had not been updated to reflect this.
●Medicines audits were not being completed.

Medicines were not managed safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

●During our inspection the acting manager acted immediately upon discovering that staff competencies relating to the administration of insulin were out of date and arranged for the district nursing team to administer one person's insulin to ensure they were safe.

Staffing and recruitment
●Systems were not always operated effectively to ensure staff were recruited safely.
●Disclosure and Barring 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's file did not contain evidence that a DBS check had been obtained. There was also no evidence that references had been sought for this member of staff.
●A second staff member's recruitment file did not contain an application form, any work history, or an interview record.
●There were no systems in place to assess any risk to people living in the service where staff had criminal convictions.

Recruitment procedures were not operated effectively. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

●Staff told us that there had been regular staff shortages recently due to an outbreak of Covid-19, but that prior to the outbreak staffing levels had been sufficient. The provider told us the recent staffing issues were a direct result of staff illness and a shortage of agency staff, and they continued to invest heavily in recruitment.
●One staff member told us, "The senior (care staff) have been here a long time and do their best." Another said, "The staff team has really pulled together."
●People's families gave mixed feedback regarding staffing levels. One family member told us, "They're short staffed, even before the pandemic they always seemed quite pressed for time." Another said, "They're always busy but there seems to be enough."

Preventing and controlling infection
●The risk of the spread of infection was not well managed.
●We observed poor mask wearing practice by a number of staff over the two days of our visit. This included one staff member wearing their mask under their chin whilst sitting next to people, and another member of staff wearing their mask under their chin in communal areas on both days of inspection.
●There were no cleaning schedules in place in relation to high touch points and no checks being made that regular cleaning was being carried out.
●Some equipment was in a poor state of repair and therefore difficult to keep clean. For example, a toilet aide in one of the bathrooms had rusty metal on the frame.
●On the second day of our inspection we observed dirty laundry being stored directly next to clean laundry, which posed an infection control risk.

The risk of the spread of infection was not well assessed or controlled. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

●Staff had access to personal protective equipment and knew when they should be using it.
●The services' policies had been updated in light of Covid-19.
●People's families told us the home was clean and odour free.

Visiting in care homes
●At the time of our inspection, the service was experiencing an outbreak of Covid-19 and some restrictions were in place, however visits were still being supported. We observed one person having a visitor in the conservatory on the first day of our inspection.
●One family member told us they felt frustrated they couldn't take their loved one out. They said, "I can't see why we can't take her out for a drive."
●Feedback from another person's family member given during the pandemic said they would appreciate more communication whilst visiting was restricted, "Maybe a blog post with photos, or Zoom calls." It was not clear if any action had been taken to improve communication.

Systems and processes to safeguard people from the risk of abuse
●No notifications of abuse or neglect had been made by the service since our last inspection, however, four alerts had been made by health professionals in the past twelve months. Concerns included two people experiencing a number of unwitnessed falls. One had no care plans in place, and the other sustained a fractured arm.
●A third safeguarding alert related to a failure to seek medical input where a person had not eaten for four

weeks.

- All but three staff members had completed safeguarding training within the past twelve months.
- Staff told us they would raise any concerns with the manager and felt comfortable doing so.

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.

- Some people living at the service were being deprived of their liberty, however, the service was not always working within the principles of the MCA.
- One person was living with dementia and had a known history of attempting to leave their own home when it was not safe to do so, including at night. Care records stated this person had been increasingly confused and staff told us that on a number of occasions they had been found outside of the property. A capacity assessment had not been completed and a DoLS application had not been made.
- Three further service users were living with dementia. One of these people's care notes stated they had "some difficulty" understanding and being understood and another's care notes said they had lacked capacity to make a decision the previous year. No capacity assessments had been completed in relation to any decisions.
- A fourth person had been assessed as lacking capacity to consent to care and treatment and a DoLS application had been made. Staff used an alarm mat to alert them to the person moving, which may have put them at risk. This is a form of restrictive practice. Staff had not completed a capacity assessment in respect of this and had not recorded they were carrying out this restrictive practice in the persons best interest. As a consequence, there was no legal basis for this restriction.

Care was not always provided with the consent of the relevant person or in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act

2008 (Regulated Activities) Regulation 2014.

Staff support: induction, training, skills and experience
●Most staff had completed training in the areas the service identified as mandatory, such as safeguarding and moving and handling. However, the service had not identified that staff required training around individual health needs and conditions, such as dysphagia, diabetes or the management of Parkinson's Disease.
●New staff worked alongside more experienced staff when they started work, however, they did not complete a formal induction. One staff member who had worked at the service for eight months told us, "I've not had an induction or a review."
●Staff told us they did not have regular supervision.

We recommend the provider ensure staff complete appropriate induction, supervision and training to ensure they have the knowledge and skills to meet people's individual health needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
●People's care was not always delivered or continually assessed in line with their desired outcomes. Two people's family members told us they had not been kept up to date regarding their loved ones respite placements at the service and had not been involved in reviews of their care.
●Staff worked with other health professionals where they recognised a need to do so, however, there were occasions where they did not recognise the need to involve other health professionals or take action to follow up requests for assessments.
●Staff did not always support people to access healthcare services in a timely way. For example, one person admitted to the service in early 2021 had very poor hearing and relied on hearing aids. These were broken at the time of admission, and their family member told us, "They've never been mended or replaced. I raised it with the home a couple of times, and they say, 'oh we'll chase it up'."

Supporting people to eat and drink enough to maintain a balanced diet
●People told us they enjoyed the food and were offered choices.
●The chef told us they had been working on devising new menus and had been gathering feedback from people as part of this progress.
●We observed people enjoying a meal on the first day of our inspection, one person told us it was, "Very nice."
●One person's family member told us their loved one "says the food is very good".

Adapting service, design, decoration to meet people's needs
●Modifications had been made to the period property to adapt it to better suit peoples' needs, such as the creation of a wet room.
●Peoples' rooms were personalised with their own belongings.
●There was sufficient communal space for people to have a choice of where to spend their time or to see visitors. The well-maintained gardens also had a visiting pod which had been installed to support safe visiting during Covid-19.

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 our last inspection we rated this key question good. At this inspection the rating has changed to 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; Supporting people to express their views and be involved in making decisions about their care

- People's privacy and dignity was not always respected.
- On the first day of inspection, we saw a member of staff assist one person into the lounge having assisted them to the toilet. They were holding a clear plastic bag with a visibly soiled pad inside it and continued to speak to a number of different people before going to dispose of the clinical waste bag.
- We also observed staff discussing people's care with each other in communal areas. One staff member said, in front of a number of other people, "Whoever's got (person's name's) book, I soaked her feet this morning."
- The language staff used was not always respectful, for example, referring to people who need the assistance of two staff as "doubles".
- People were not always supported to be independent and we saw people trying to stand up and move being repeatedly asked to sit back down. One staff member asked a person where they wanted to go, they responded "anywhere", before sitting back down.
- There were no formal systems in place to involve people to express their views or to be involved in their care.

People were not always treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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

- We saw warm relationships between staff and people, and people and their families told us they felt the staff were caring. People were well dressed. One person's family member said their loved one, "Always looks well, clean, tidy and shaven."
- We observed one care assistant helping a person to mobilise from one room to another, the care assistant said, "I'm so proud of you, that really was a lot of walking."
- One person told us the staff were "wonderful", and another said, "They're very kind, and jolly, I'm happy here."
- One person's family member told us how the registered manager had arranged for staff to go to the person's home to collect items of furniture that were important to them, so they felt they were moving into their own home with their own belongings, and made sure they could get their favourite religious radio station through the television.
- Comments from people's families included, "Staff are caring." "Immensely kind." And, "The girls are really

nice."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- Three people did not have any care plans in place. There was no guidance for staff as to how to meet these peoples' needs or what their preferences were.
- Care plans that were in place were very brief, basic and task orientated, and had not been regularly reviewed or updated to reflect people's changing needs.
- Care plans contained limited information about people's likes, dislikes, life history or how they liked to spend their time.
- There were no end of life care plans in place, despite regularly caring for people at the end of their lives. Nine people had passed away at the service in the past twelve months.
- There were no details in peoples' care plans that reflected what time they liked to get up. Staff told us that there were some routines in place that appeared to suit the staff, rather than people. For example, one person was assisted to get up at 6am every day because "it's always been that way". Another member of staff told us that this person is "always done."
- Night staff told us that, whilst there were no set rules, there was an expectation they would assist a certain amount of people to get up, wash and dress before the end of their shift at 8am. One staff member told us, "There are a couple of doubles to get up and sorted." Another told us they "try to fit in a couple more" to help the day staff.

Care and treatment did not meet people's needs and reflect their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- Some people living at the service were able to express their preferences and choices and were supported appropriately in line with these.
- Some staff had worked at the service for many years and knew people well.

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

- There was limited support for people to avoid social isolation, follow interests and take part in activities.
- A staff member was allocated to spend time with people and provide activities for two afternoons per week, however they were often required to cover care shifts instead. They told us "not much has been happening."
- Some people were able to follow their own interests such as artwork or reading the daily paper, however others were not. When we asked one person what they did all day that told us, "We just sit."

●Care staff had limited time to spend with people in their rooms. One person's family member told us their loved one was, "Isolated in a room and can't hear anything." No records were no records to demonstrate staff spending any time with them outside of delivering personal care.
●Some people said they would like to use the outside space more frequently. One person said they would like to go out but were "not allowed." Another person's family member said, "She'd like to go out a bit."

Care and treatment did not meet people's needs and reflect their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

●Staff told us that outside entertainers were due to start visiting again soon.
●Some people were able to communicate well and formed friendships with each other. We observed people enjoying spending social time together.

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.

At our last inspection we found people's care plans included information on how people's communication needs could be supported. However, information at the home had not been provided to people in differing formats if they had a communication difficulty. We recommend the service consider how information could be made available to people to support assisted communication where they may benefit from this. At this inspection we found no progress had been made.

●People did not always have the support they needed to communicate. For example, one person had very impaired hearing and relied on a hearing aid, but this was broken.
●A second person told us they enjoyed keeping up with current affairs, but they had bad hearing and "can't hear what's going on". It was not clear if any action had been taken to support them.
●Another person was registered blind, there was no care plan in place around how to support this person. On the second day of inspection we saw them in their room alone, trying to find their call bell. This had been left slightly out of reach and we assisted the person to call for help.
●There were no printed menu's available to help people choose their meals.

We recommend that the provider put systems in place to ensure the Accessible Information Standard is met.

Improving care quality in response to complaints or concerns
●There was no record of any complaints received since our last inspection.
●We received mixed feedback from people's families. One family member told us, "My brother has complained but he hasn't had any satisfaction." The complaint had not been recorded and there was no record of any action taken.
●Another person's family member said, "I have a few minor concerns, I would normally speak to the registered manager, but they have been off for quite a long time now, I don't find I get the answers off the other staff, there doesn't seem to be a nominated person around." A third persons family member told us, "I feel I can raise things, but I need to tread quite carefully."

●Other family members gave more positive feedback. One said, "I've never had to make a complaint, but I feel they would take it on board if I did." Another told us, "I've got no complaints."

We recommend that the provider put systems in place to ensure complaints and concerns are recorded and responded to.

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There were no quality assurance systems or processes in place to ensure the service was well led.
- The registered manager had delegated all risk assessment and care planning to senior care staff, however, they did not have the time to ensure these were completed. They had not been completed and there had been no reviews or audits to check this.
- There were no systems in place to audit medicines, incidents, accidents or care plans. As a result, the service had failed to identify and act on risk and had failed to provide a service that met people's individual needs and preferences.
- There were no systems in place to ensure people had their rights protected under the Mental Capacity Act.
- Recruitment systems had not been operated effectively and there were no systems in place to ensure staff received regular supervision.
- There were no systems in place to record, review or audit complaints and concerns to identify themes and trends.
- The provider did not have any quality oversight systems in place. They told us they visited the service regularly and were available for support but did not undertake any quality checks.
- There were no systems in place to ensure continuous learning and there was no service improvement plan.

The service was not well led. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- Notifications were not always made in line with legal requirements.
- Records said eight people had serious injuries between July 2021 and March 2023. Injuries sustained were significant and some required hospital treatment. No notifications had been made to the Care Quality Commission in respect of these injuries.

Notifications were not made in line with legal requirements. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

●People and their families were not involved in their care planning. We asked one person's family member if they had been involved in reviewing their loved ones care. They told us, "I didn't even know there was such a thing. I've never been involved in care planning." Another said, "They haven't involved me in care planning or reviews."
●There were no systems in place to seek feedback from people using the service.
●We saw that some feedback had been sought from some family members, however it was not clear if any action had been taken in response to the feedback received.
● Staff told us they did not feel supported, and felt morale was "very low". One staff member told us, "I love working here, but you dread coming to work because you don't know what it's going to be like."

The culture of the service did not promote good outcomes for people. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Working in partnership with others
●The service did not work effectively in partnership with others.
●In 2021 the local authority had spent time with the registered manager. This was a supportive intervention to improve care planning and record keeping and a number of resources were provided. None of the advice given was implemented.
●The registered manager worked in isolation and there was no partnership working with the other two homes in the group.

The service did not always work well in partnership with others. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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;
●Duty of candour was not always fulfilled because incidents were not always recorded and were not analysed and so the service did not always identify where things had gone wrong. For example, where a person had been at risk on an unknown number of occasions by leaving the property alone when they were not safe to do so.
●Peoples' relatives told us staff always told them if their loved ones were unwell. One said, "They are good at communicating if they ever need to call the Dr. they tell me straight away."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment did not meet people's needs and reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not always respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care was not always provided with the consent of the relevant person or in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively.

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 12 HSCA RA Regulations 2014 Safe care and treatment The service did not assess, monitor or mitigate the risks to peoples' safety. Medicines were not managed safely. The risk of the spread of infection was not well assessed or controlled.

The enforcement action we took:

We imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no systems or processes in place to ensure the service was well led. The culture of the service did not promote good outcomes for people. The service did not always work well in partnership with others.

The enforcement action we took:

We imposed conditions on the providers registration.