Yew Tree Residential Care Home Limited

Yew Tree Residential Care Home

Inspection report

60 Main Road
Dowsby
Bourne
Lincolnshire
PE10 0TL

Tel: 01778440247

Date of inspection visit:
12 October 2022

Date of publication:
04 May 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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Yew Tree Residential Care Home is registered to provide accommodation for up to 18 people requiring nursing or personal care, including older people and people living with dementia. There were 15 people living in the home on the day of our inspection.

People's experience of using this service and what we found
People were not protected from potential abuse as there was a lack of processes in place to robustly monitor and investigate allegations of abuse.

Environmental safety hazards identified at our last inspection had not been addressed and the risks to people's safety were not well managed. This included a lack of a clear evacuation strategy, open stairwells posing a risk to people who were living with dementia and mobility issues. Moving and handling equipment was not regularly serviced and there were incorrect slings for people who required hoisting support. Bed rails which could cause entrapment were in place and there was a lack of bed bumpers.

Medicines were not well-managed. Some prescribed medicines were not in stock for people and people were not receiving their medicines as prescribed. Risk assessments and care plans were not up to date and contained conflicting information on people's care needs.

Infection prevention and control measures were not robust. A number of raised toilet seats had body fluids on them, plastic spout cups in use were not clean and good hygiene practices were not carried out in the kitchen.

There was a lack of staff, and safe recruitment processes had not been followed. Staff had not always received appropriate training and support for their roles.

People's nutritional needs were not always well managed.

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.

Although staff were kind and caring people were not always well supported and this impacted on their emotional and physical well-being. People's care records did not always contain enough information for staff to be able to provide personalised care. People's social needs were not well met.

The service was not well led. Shortfalls in organisational governance found at our last inspection had not been addressed and systems designed to ensure safety and the quality of care people received remained ineffective.

There was a lack of provider oversight and learning from events.

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

Rating at last inspection and update
The last rating for this service was inadequate (8 July 2022) and there were breaches in regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well Led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Yew Tree Residential Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified eight breaches of regulations relating to the assessment and management of risks; staff training; staff recruitment; protection of people's rights under the Mental Capacity Act (MCA); safeguarding people from abuse; managing nutrition; providing person centred care and organisational governance. 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 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 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.

We will also 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 remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Yew Tree Residential 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.

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

Inspection team
The inspection team was made up of one inspection manager and one inspector. An Expert by Experience undertook telephone calls to relatives following our site visit. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Yew Tree Residential Care Home 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. Yew Tree Residential Care Home 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 not a registered manager in post and the home manager was off sick, the service was being run by the deputy manager. We will continue to monitor this.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We conducted one site visit as part of this inspection; on 12 October 2022.

We spoke with the owner of the company registered to operate the care home (The provider); the deputy manager; 1 member of the care team and 1 housekeeper. We also spoke with 3 people about their experience of the care provided.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of written records including 6 people's care files, 3 staff recruitment files and information relating to the auditing and monitoring of service provision.

After the inspection
We reviewed further information we had requested from the provider, including staff training records. We also contacted 6 relatives and friends to seek feedback on their experience of the service.

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 Inadequate. At this inspection the rating has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider was in breach of Regulations 12 (Safe care and treatment) and 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to properly assess and manage a wide range of risks to people's personal and environmental safety and placed people at risk of avoidable harm.

At this inspection we found further concerns and the provider has remained in breach of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, at this inspection we have reported on the issues raised under Regulation 15 at our last inspection, under Regulation 12 as the failures now posed a risk to people's safe care and treatment.

Assessing risk, safety monitoring and management

- People were at risk of harm in the event of a fire at the service. A visit from the Lincolnshire Fire and Rescue service on 8 August 2022 showed the service's emergency plan did not provide a clear evacuation strategy. There had been no work undertaken to address the concerns found by the fire service and people remained at risk of harm.
- Further environmental risks in relation to open stair wells meant people were at risk of avoidable harm. One person who lack capacity walked independently around the home and a member of staff told us they would try to access the stairs in periods of confusion. Their care plan documented they were at risk of falls and often forgot to use their walking aid, there was no information in the care plan about the risk posed by the open stairwells. The risk posed by the open stair wells had not been assessed and mitigated and placed people at risk of falls and consequent harm.
- People were at risk of receiving unsafe care and consequent harm as there were not sufficient care plans and risk assessments in place. Pre-admission assessments, care plans and risk assessments had not been completed for people who had been recently admitted to the home and changes in people's needs were not assessed or planned for.
- One person admitted to the service on 6 October 2022 had no care plans or risk assessments in place at all. A further person admitted in August 2022 had a basic respite care plan in place and no risk assessments. In respect of this person, an NHS patient summary form documented an extensive list of health conditions including dysphagia (difficulty swallowing), posing a risk of choking. There was no care plan or risk assessment in place in relation to this and we saw the person ate an unmodified diet with no supervision at lunch time.
- Staff told us following a recent hospital admission, a further person's needs had changed. This had resulted in them needing bedrails, requiring hoisting and there had been an increase in distressed reactions. Staff had not been provided with sufficient guidance on how to meet the person's increased needs. This put the person at risk of receiving unsafe care.

● Moving and handling equipment was not used safely. The hoists in the service required six monthly servicing but had not been serviced since September 2021. People were not provided with the slings documented in their care records. Two people had incorrect sling types; one person had the wrong size and one sling we viewed had a worn label, so it was not possible to see the size. The layout of one person's room did not enable safe hoisting practices. This put people at risk of receiving unsafe care and put staff at risk due to using moving and handling equipment unsafely.
● People who required bed rails did not receive safe care. The bed rail risk assessments stated there were no gaps between the bed rail and bed ends. However, the four beds with rails we viewed all had gaps of 40cm between the end of the bedrail and bed. One person had been assessed as needing bed bumpers which were not in place and a further person's bumpers had come away from the metal bed rails on one side. This increased the risk of entrapment and consequent harm for these people.

Using medicines safely
● People's medicines were not managed safely and effectively. There was not always a medicines trained member of staff on duty at night. This meant if people required medicines on an 'as required' basis during the night, there were insufficient arrangements to ensure people would receive them in a timely way.
● People were not receiving their medicines as prescribed. Several prescribed medicines were not in stock and had been written on the medicine administration records (MAR) as not being given for over a week. One person was prescribed a pain killer gel which was not in stock, and there was no record of this being administered. There were no medicine administration records (MAR) for some people who were prescribed pain medicines. One person had been issued with 60 pain killing tablets in June 2022, we found 24 tablets left but no record of the other 36 tablets having been administered.
● People's MARs did not always correspond with the number of tablets we found. One person's blood pressure medicine contained 28 tablets when first opened on 31 August 2022. At the time of our inspection, there was one tablet left in the box. However, the person should have received 43 tablets in that time span. There were no running totals on the person's MAR, so we were not assured the person had received the medicines they required.
● People who had been administered skin patches containing medicines for pain relief had no recording of where the patches had been placed on their bodies. Patch rotation is required to prevent skin damage. Failure to do so places service users at risk of harm.
● There was a lack of clear information for people who required medicines to be either crushed or administered covertly. One person's MAR and care plan documented their tablets were to be crushed and administered covertly in food. There was no explanation of why and no best interest meetings had been undertaken. There was no information to show professional advice had been sought to determine what foods it was safe to administer the medicines in.

Preventing and controlling infection
● Infection prevention and control practices at the service were not robust and put people at risk of harm through the possible spread of infection.
● Throughout the service we found concerns with cleanliness. A number of raised toilet seats had body fluids on the underside of the seats. Bed bumpers and bed rails were stained with a brown substance. Plastic spout cups in use had debris around the spouts. The clinical room used to dispense medicines had cracked and damaged tiles, dirt and debris on the medicines cupboard doors and when we observed staff dispensing medicines from this room, we saw empty used medicines pots were left in the handwashing sink.

Learning lessons when things go wrong
● People were at risk of harm as opportunities to learn from incidents and reduce future risk were missed.

There was no evidence of learning from incidents. There had been no analysis or review of falls / incidents since May 2022. Accident analysis forms for June, July, August and September 2022 were blank. Accident forms were missing, so we were unable to determine what incidents had occurred or what action had been taken to reduce the risk of reoccurrence.

Failure to effectively manage the risks to people's safety was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider was also in breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) as they had failed to maintain effective systems to safeguard people from the risk of abuse.

Systems and processes to safeguard people from the risk of abuse

● People were not protected from potential abuse as there was a lack of processes in place to robustly monitor and investigate allegations of abuse putting service users at risk of harm. CQC received a notification from the local safeguarding team regarding an alleged serious incident of abuse. There were no investigation records of this serious incident,

● One person had made a complaint to the service regarding the way a member of staff had treated them. Although the manager had undertaken an investigation into the complaint they had not recognised the incident should be reported to the safeguarding team or CQC.

● The safeguarding folder we viewed during our inspection was empty and there was no evidence of learning from these alleged incidents.

The provider's failure to maintain effective systems to safeguard people from the risk of abuse was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People were not always supported with enough staff to meet their needs. On the day of our visit there were three members of care staff on duty. However, one staff member was the deputy manager who was also responsible for the running of the service. There was no administration support as the administrator was on annual leave and the care plan coordinator was acting as cook for the service on that day. The deputy manager told us both they and the manager regularly needed to support care staff and work extra shifts to ensure care was provided.

● People were not sufficiently supported at night, the staff rosters showed there were two members of staff working at night. Four people required 2 members of staff to assist them with their needs. One person as stated above was frequently awake at night and might sometimes be awake for over 48 hours at a time. Staff were unable to effectively supervise the person and maintain their safety.

The lack of staff was a breach of Regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had not always been supported by staff who had undergone proper recruitment checks. We found multiple concerns about how staff were recruited, including a failure to obtain evidence of recruitment checks, such as Disclosure and Barring service (DBS). These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● Prior to our inspection, due to staff shortages the manager had brought staff in to cover a shift who had

not undergone proper recruitment checks. The manager told us they were now aware this was not acceptable practice as it put people at risk of receiving care from staff who may not be suitable for their roles.

● During inspection staffing rosters showed that the provider was working some care shifts, we saw there was no DBS in their staff file. We requested this, but we were not provided with any evidence that the nominated individual had a DBS check in place.

The failure to have safe recruitment processes in place was a breach of Regulation 19 (Fit and proper persons employed) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

● The provider was following the government guidance in relation to supporting people to have visitors at the service. Relatives told us they were able to visit their family members and were provided with appropriate personal protective equipment (PPE) to support the reduction of the spread of infection.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question Inadequate. The rating for this key question has remained Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

At our last inspection we found the provider was in breach of Regulations 18 (2a) (Staffing), and Regulation 11(Need for consent), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found they were still in breach of these regulations.

Staff support: induction, training, skills and experience

- People were not always supported by staff who had the necessary training for their roles.
- This impacted on staff's ability to carry out their roles safely. On the day of our visit the cook was not on duty and the care plan coordinator was undertaking kitchen duties. This staff member had not received food safety, hand hygiene, infection prevention and control or nutrition and health training. Following the lunchtime meal, we found cooked food from the previous meal had been left on the work surfaces in the kitchen. We also found foods in the fridge which had been opened with no opening dates on them.
- The duty roster showed the provider was working shifts supporting with care when the service was short staffed. However, the provider had not undertaken any training to support them in their role.
- The manager who had been in post for approximately 6 weeks had not had any training since starting in their role. During our inspection we checked the staff file of the manager, there was no evidence of training in previous posts. This lack of training and support for staff put people at risk of receiving care from staff who lacked the necessary skills for their roles.

The failure to provide staff with the necessary training for their roles was a continued breach of Regulation 18 (2a) (Staffing) 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. The provider was not working in line with the principles of the MCA.

● One person who had been assessed as requiring a DoLS did not have a valid up to date DoLS in place. There was information to show their DoLS had expired in 2020, the previous registered manager had requested a renewal of the DoLS in April 2022. An urgent 7-day DoLS had been put in place in May 2022, but there was no evidence of this being followed up by the previous registered manager or present manager. This meant this person was being deprived of their liberty unlawfully.

● Several people lacked the capacity to provide consent to different aspects of their care. The provider had not used the principles of the mental capacity act to effectively show treatment and care was provided in service users' best interests.

● For example, one person had capacity assessment documents for specific decisions in their care plan. The documents only gave details of the assessment of the person's capacity and all were completed using the same wording, noting the person's lack of capacity to make decisions. There was no evidence to show what decisions had been made about the person's care or that any advice or support had been gained from health professionals, relatives or advocates to ensure any decisions taken were in the person's best interests and were the least restrictive option.

The provider's failure to protect people's rights under the MCA was a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care

● People's nutritional needs were not met in a safe way as there was a lack of guidance for staff to ensure people were supported safely. There was a lack of documentation in the kitchen to provide guidance for staff on people's individual nutritional needs.

● As described in the safe section of this report one person had information on an NHS patient summery form dated 30 August 2022, noting they had difficulty in swallowing (dysphagia), posing a risk of choking. There was no care plan or risk assessment in place in relation to swallowing or choking and we saw the person ate an unmodified diet with no supervision at lunch time.

● A further person's nutritional care plans showed they required support when eating. Their care plan noted they required a pureed diet, but there was no information as to the level of pureed diet the person required. There was no evidence of any assessments being carried out by or on behalf of the Speech and Language Therapy (SALT) team. This lack of assessment put the person at risk of receiving a level of diet which did not meet their needs and put them at risk of choking.

● We observed two pots of Thick and Easy (starch-based thickener which can be used to alter the consistency of foods) were stored in one person's bedroom, this posed a risk of ingestion by other service users who resided upstairs and were mobile. This was not in line with the 2015 NHS England Patient safety alert - Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder https://www.england.nhs.uk/2015/02/psa-fluidfood-thickening-powder/.

The failure to meet people's nutritional needs in a safe way was a breach of Regulation 14 (Meeting nutritional and hydration needs)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The service was warm and welcoming, however as mentioned in our safe section of this report some areas of the service such as the open stairwell continued to put people at risk of harm.

● There was also a lack of easy read signage to support people living with dementia to find their way around the service to key areas such as toilets.

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

● Assessment tools used to assess people's needs were not always up to date and reflective of people's current needs.

● Care plans we viewed showed assessments such as Waterlow scores (assessments of people skin integrity) had not been carried out since May 2022, for several people. This put people at risk of not receiving appropriate care for their current needs.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection this key question was rated Good. At this inspection we rated this key question as Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- We found some people were not well supported and this had a negative impact upon their emotional wellbeing.
- One person told us they chose to spend all their time in their room. They said they did not see anyone for hours on end and they were looking for ways to end their life. Their care plan documented the person had capacity to make decisions, no mental health needs and emphasised the importance of social interaction. However, daily records showed interactions were limited to times when care was provided, demonstrating their social needs were not met, which may have had a detrimental impact upon their mental health and wellbeing.
- Although we saw staff's daily interactions with people were positive, there were times when people's dignity was not maintained or promoted. Some people were left for long periods of time without support and this had resulted in some behaviour patterns that impacted on people's dignity.

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

- People who lacked the capacity to make their own decisions were not always supported with the services of an independent mental capacity advocate (IMCA). An IMCA is an independent person appointed to act on a person's behalf if they lack capacity to make certain decisions.
- One person's care records contained contradictory information on whether they had an IMCA in place. In one section of their care plan it was noted an IMCA was not required and in another section it was noted an IMCA was required. However, there was no information to show an IMCA had been contacted or visited the person. The person lacked the capacity to make their own decisions and had no legal next of kin. The lack of an independent advocate could mean the person's wishes or views were not supported.
- People's views on their care were not always documented and relatives told us they had not seen or been involved with the development of their family member's care plans. This meant people's wishes or views on their care may not have been captured.

The provider's failure to provide person-centred care to meet people's needs was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- More positively, we received some good feedback from relatives about staff's attitude towards their family members when providing care. One relative said, "I think the staff have a lot of patience and are very understanding with the residents. They are always prepared to guide them into appropriate places when

required, like the dining room." Another relative said, "Yes, the staff are very caring I must say, and I have certainly seen this when I have been there."

● Several relatives felt they were involved in their family member's care and could discuss this with care staff. One relative said, "I have never seen any care plan for [Name] and they have not discussed anything like that with me. I do though feel sufficiently informed about [Name's] care."

Inadequate

Is the service responsive?

Our findings

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

At our last inspection this key question was rated as Good. At this inspection we rated this key question as Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

● People did not always receive personalised care which met their needs. People's needs were not always assessed when they moved into the home. People who had been admitted to the home did not always have sufficient care plans in place to guide their care and support. One person only had an NHS discharge summary to support staff. The document showed the person had significant physical health needs and religious preferences. There were no care plans in place about their health needs or preferences in relation to their religion, this posed a risk their needs and preferences may not be met.

● A further person was admitted to the home approximately two month prior to our inspection. A pre-service assessment form, dated the same date as their admission, had been completed with basic administrative details only. Sections relating to their care needs and preferences were blank. An NHS patient summary form, dated 30 August 2022, documented an extensive list of both mental and physical health conditions. There was no care plan in place in relation to any of the person's physical or mental health needs. This posed a risk their needs and preferences may not be met.

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 social needs were not always met. Relatives we spoke with told us they were able to visit their family member on a regular basis. However, several relatives felt there was not enough social activities going on to stimulate people.

● Our observations supported this view. People were left for long periods of time with little staff interaction other than to provide personal care or support with meals. Daily records showed that, since a change in their needs, one person spent most of their time in bed, they did not have a TV in their room (a staff member advised it had broken) so they only had a radio to occupy them. Daily records showed they had increasingly frequent periods of distress and there was no evidence that staff had tried to provide stimulation to reduce the person's distress.

● A further person spent all their time in bed although their social care plan noted they should receive regular one to one care, focusing on their senses. During our inspection we observed they had no social interaction with staff throughout the day other than personal care. There was no TV in their room and no sensory stimulation such as music. A member of staff later advised that their stereo was broken and had not been replaced. This lack of stimulation did not meet their social needs.

End of life care and support

● Information around people's wishes and choices in relation to their end of life care was variable. Some care plans for people who had resided at the service for several years had clear information of their wishes

and detailed conversations had taken place. However, people who had been admitted to the service more recently had very little information on their needs and preferences. This meant people's end of life care wishes may not always be supported in the way they wanted.

The provider's failure to provide person centred care to meet people's needs was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

● People's care plans did not always give information on how their communication needs should be met. One relative told us their family member was deaf and staff would spend time repeating things to them, so they understood. However as mentioned in the Effective section of this report, there was a lack of signage or visual aids which may have supported people's communication needs

Improving care quality in response to complaints or concerns

● Relatives told us their concerns or complaints were listened to by staff. However, one relative told us the issues raised were not always addressed in a timely way. They were still waiting for some issues they had raised about their family member's room to be addressed.

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 Inadequate. At this inspection the rating for this key question has remained 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.

At our last inspection the provider was in breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They had failed to implement systems and processes to oversee the safe and effective leadership and management of the service. At this inspection we found no improvements had been made and the provider was still in breach of this regulation.

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

- Systems to ensure the safety and quality of the service were not effective. Although there were auditing systems in place, no audits had been undertaken since May 2022, this meant that many of the issues highlighted in this report had not been identified or addressed prior to our inspection.
- The provider did not have any effective oversight of the safety of the home. They had total reliance upon the management team to ensure the safe and effective running of the home. The provider did not compete any formal audits of the quality or safety of the service. Consequently, they were not aware of issues we identified at inspection. The provider told us that they hoped things were back on track and were hoping for an improved rating, this demonstrated a lack of knowledge and understanding of the safety concerns at the home.
- The provider had failed to implement an effective system to learn from adverse incidents and improve care. Due to the absence of accident records as highlighted in the safe section of this report, there was no evidence of learning from themes and trends of incidents or falls to reduce recurrence. This meant that opportunities to identify themes and trends and take action to reduce risk may have been missed.
- The provider had failed to learn and improve care. Action had not been taken to make improvements following our April 2022 inspection. Following this inspection, the provider submitted an action plan, dated 10 July 2022, detailing what steps would be taken to improve care and safety and achieve compliance with the regulations. All actions were scheduled to be completed by 1 August 2022. During our inspection we found that many of these planned actions had not been undertaken.
- People's health and safety was at risk at the service as there was insufficient leadership and management to ensure the safe and effective running of the home. At the time of our inspection the manager was off work, no cover had been deployed in the home, so the deputy manager was running the home and working a care shift. The cook and administrator were on annual leave. The deputy manager told us that due to staffing issues they and the manager had to cover care, housekeeping and catering shifts which had left them with little time to run the home.
- The service did not have a registered manager in post. Since our last inspection the registered manager had left the service and at the time of writing this report the manager had stepped down. The service was

being run by the deputy manager.

The provider's continued failure to implement systems and processes to oversee the safe and effective leadership and management of the service was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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

● Notifications are events which happened in the service that the provider is required to tell us about. Although we had received statutory notification about events in the service, as highlighted in the safe section of our report the manager had not recognised a complaint they investigated should have been raised as a safeguarding issue to both CQC and the local authority .

The provider's continued failure to implement systems and processes to oversee the safe and effective leadership and management of the service was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On a more positive note relatives told us the manager and staff at the service were open with them about events that occurred affecting their family members.

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

● There was no evidence of any relatives and residents' meetings and relatives we spoke with told us they had not completed any recent questionnaires or surveys. However, relatives told us they felt involved and engaged with the staff at the service. They were aware there had been several staff changes recently but felt staff were approachable.

● There had been a number of staff who had left the service prior to our inspection, the staff who were left told us they were working with the management team to improve the service for people and they had been involved with staff meetings. We saw records to show meetings had taken place to introduce the manager, discuss topics such as health and safety, IPC, safeguarding, confidentially and respect, medicines and staffing.

Working in partnership with others

● Since our inspection the provider and staff have been working with the local authority support teams to work to improve the quality of the service being provided for people. We will continue to monitor this.

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 provider failed to effectively manage and mitigate the risks to people's safety.

The enforcement action we took:

We imposed urgent conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to implement systems and processes to oversee the safe and effective leadership and management of the service.

The enforcement action we took:

We have imposed urgent conditions on the provider's registration