Park Homes (UK) Limited

Claremont Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Claremont Care Home that can accommodate up to 63 people who require support with nursing or personal care needs, some of whom were living with dementia. The provider was also caring for people with learning disabilities and autism, but this was not included in their registration.

At the time of our first visit, 51 people were living at the service. On our second visit, there were 52 people living at the home.

People's experience of using this service and what we found
During this inspection, we found widespread shortfalls in the way the service was managed and we were not assured the service provided safe care. We found signs of a closed culture developing at the service.

People did not always receive safe care. During this inspection, we identified and reported several safeguarding concerns. Some people and relatives told us the service did not provide safe care.

People were not always safe because systems in place were not effective to monitor risks to their health and incidents that had happened. This included individual risks, environmental risk and fire safety risks. Several people living at the home had lost weight and appropriate action had not always been taken in a timely way.

People's medicines were not always administered safely.

Good infection prevention and control procedures and relevant guidance regarding testing, visiting and vaccination as condition of deployment were not always being followed. Systems to learn lessons were not always effective.

Staff deployment and the management of the shift was not effective to ensure people's needs were met in a timely way. We received mixed feedback regarding staffing levels at the service. On review of all information gathered during this inspection, we have made a recommendation for the provider to review their staff deployment practices.

Staff had not been supported to have the appropriate knowledge and skills to deliver safe and effective care. We found training was not kept up to date and staff were not offered regular supervision or appraisal meetings.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or

autistic people. The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. The model of care was not consistent with current best practice. The management of behaviour considered challenging to others did not follow a positive behaviour support approach. People were not supported to take part in activities that were meaningful to them and that promoted their independence.

We found there were coded key pads in the building that could be an unnecessary restriction for some people, as these prevented people from moving through the home freely. We found inconsistency in the application of the principles of the Mental Capacity Act. We made a recommendation for the provider to review this practice. 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. There were policies and systems in place, but these weren't always being followed in practice.

People did not always receive person centred and dignified care. We observed staff not being responsive to people's needs. There were a lack of meaningful activities and interaction being offered to people. We observed people's dignity not always being protected. We made a recommendation in relation to promoting people's dignity and privacy.

The provider failed to implement processes to effectively monitor the quality of the service and to identify the issues found during our inspection. Records were not always complete or contemporaneous.

We found widespread shortfalls in the way the service was managed, in particular a lack of management oversight and accountability. There was a risk of people receiving inappropriate care. Although some checks were being conducted on behalf of the nominated individual, these did not ensure that all issues were identified or that issues identified were timely acted upon.

The management team collaborated with the inspection process and told us about the plans they would put in place to address the issues found during this inspection.

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 requires improvement (published 13 May 2021)

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
We undertook a focused inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about moving and handling, pressure care, unexplained bruises, weight loss, fire safety, staff's training, staffing levels, medicines management, management of the home, hygiene and infection control. A decision was made for us to inspect and examine those risks.

We inspected and found there were further concerns with people not receiving person centred and dignified care, so we widened the scope of the inspection to become a comprehensive inspection which included the five key questions.

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

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

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 breaches in relation to safe care and treatment, person centred care and good governance 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 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.

Special Measures
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 responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Claremont 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 included checking the provider was meeting COVID-19 vaccination requirements. 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
This inspection was conducted by two inspectors on the first day, and two inspectors and a pharmacist inspector on the second day. An Expert by Experience provided remote support. 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
Claremont 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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection, we reviewed all the information we held about the service including information about important events which the service is required to tell us about by law. We requested feedback from

other stakeholders. These included the local authority safeguarding team, commissioning team, infection and prevention control team and Healthwatch Leeds. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six people using the service and five relatives about their experience of the care provided. We observed care in the communal areas to help us understand the experience of people. 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 gathered feedback from nine relatives of people using the service.

We gathered information from 19 members of staff including the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We received feedback from three healthcare professionals who had worked with the service.

We reviewed a range of records. This included four people's care plans, risk assessments and associated information, and other records of care to follow up on specific issues. We also reviewed multiple medication records. We looked at three staff files in relation to recruitment and four staff files in relation to training, supervision and appraisals. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at complaints, quality assurance records and further records of care. We contacted the fire safety authority and shared the initial findings of this inspection with the local authority safeguarding team, infection and prevention control team and with contracts managers from the local authority and CCG.

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 requires improvement. 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; Using medicines safely; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure people's safe care and treatment. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Risks to people's care were not managed safely.
- At the last inspection, we found concerns about people not being weighed as often as directed in their care plan and food and fluid records were not consistently recorded.
- At this inspection, we found several people living at the home had lost weight. We found the system in place to monitor people's weight was not effective to ensure people's weight loss was noted and actioned in a timely way. Several relatives raised concerns regarding their loved ones losing weight. We asked the provider to review the weight of all the people living at the service and make sure that appropriate action was taken if people had lost weight. We have referred information of concern to the local safeguarding team.

- We found bruises and marks noted on people had not been fully investigated. We asked the provider to investigate but we did not receive enough assurances and therefore, we reported these concerns to the local safeguarding team.
- We looked at accidents and incidents log and found concerns in relation to the number of times night staff had found people on the floor; no injuries reported. The registered manager's monthly analysis of this information had not identified any trends or patterns and therefore, no action had been considered. We asked the registered manager to review this information and consider if any actions were required to ensure people were safe.
- Systems for supporting people with their medicines were not safe. People did not always have the medicines they needed, their medication was not always administered in line with prescribed guidance and protocols for 'as and when required' medicines were not always in place. Accurate medicines records were not being consistently maintained.
- Fire safety was not well managed. Fire safety hazards were observed during our first day of inspection. Staff did not always have their fire safety training up to date. An external fire risk assessment has highlighted several risks, some of which required immediate action, but these had not been actioned in a timely way. We shared information of concern with the fire safety authority.
- People's emergency call bells were not all in working order.

● People and relatives shared mixed feedback in relation to feeling safe with the care provided at the home.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us the actions that they had taken and were planning to take to address the issues found during the inspection.

Preventing and controlling infection

At our last inspection the provider had failed to assess the risk of the spread of infections. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Several maintenance and environmental hazards issues were found during this inspection.
● The home was not always clean. Records had not been kept of the cleaning tasks completed by staff on equipment shared by people, such as hoists.
● Relatives shared concerns about the cleanliness, tidiness and maintenance at the home. Their comments included, "The carpets and floors need a good cleaning and my [relative's] room is often untidy, and the bathroom floor can do with a clean" and "My [relative's] room is always untidy and the carpet is filthy and should be replaced. The lightbulb over [their] bed has gone and I have told the manager many times the bulb needs replacing but its ignored. [My relative's] remote has gone missing so [they] cannot turn on the tv."
● We were not assured that the provider was preventing visitors from catching and spreading infections.
● We were not assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were not assured that the provider was using PPE effectively and safely.
● We were not assured that the provider was accessing testing for people using the service and staff.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were not 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.
● Relatives and friends were able to visit people living at the home, but visiting guidance was not always followed in relation to essential care givers.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found not all staff were doubly vaccinated. The provider told us these staff members had been exempt from this requirement, however no evidence was of this was produced.

Systems had not been established to assess, monitor and mitigate risks of infection to people using the service. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People, staff and healthcare professionals did not raise concerns about staffing levels. Relatives shared mixed views about staffing levels; their comments included, "There seems to be enough staff around", "Staff keep changing and they always use agency staff in the evenings and at weekends so it' is like having strangers in the home constantly, some staff don't even know my [relative's] name" and "I wish there were enough staff to take [relative] out to get fresh air, instead of [them] being kept in bed."

● During our inspection visits, we found staff were not always deployed appropriately. For example, we observed people in communal areas requiring support and no staff present to offer assistance. We observed staff who had been allocated to provide 1:1 support not doing so or supporting other people who were requiring assistance. We discussed our concerns with the registered manager and asked to take action.

We recommend the provider reviews their staff deployment practices and takes action to update their practice accordingly.

● Recruitment was conducted safety and the relevant checks carried out as required.

Systems and processes to safeguard people from the risk of abuse

● People were not protected from the risk of harm. During this inspection, we shared safeguarding concerns with the local authority because people had lost considerable weight in a short period of time and appropriate referrals had not always been made in a timely way, we found unexplained bruising had not been investigated and one person made an allegation against staff.

● Some staff members had not received safeguarding training. The registered manager was clear on their responsibilities about reporting safeguarding concerns and told us the work they had planned to develop staff's knowledge in this area.

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 good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People were not always supported in a person-centred way with their nutritional and hydration needs.
- For example, one person had lost weight and a referral had been made to the dietician who recommended a fortified diet with nourishing snacks and homemade milkshakes between meals to maximise intake. However, this person continued to lose weight. When we checked the food and fluid intake records, we noted that most of this person's intake had not been appropriate to their nutritional needs. We shared our concerns with the service manager who told us staff offered a choice of meals and snacks to this person and they often chose to have biscuits and sandwiches. This person's nutritional care plan showed they required full support from staff to anticipate and meet their needs. Another person had lost weight and their relative raised concerns that they needed support with their meals, but staff were not providing this support. We asked the service manager to review this person's support and on our second inspection visit we were informed that staff needed to offer regular support during this person's meal.
- During this inspection, we noted where some people had lost weight, this had not always been timely identified or discussed with the relevant healthcare professional. We discussed these concerns with the registered manager and service manager on the second day of our inspection, and after our inspection they confirmed people had been referred to appropriate healthcare professionals to address concerns.
- People's fluid intake records did not detail fluid targets, or the actions staff should take in the event the person had a low fluid intake.

This was a breach of regulation 12 (Safe Care and Treatment) and 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not done all that was reasonably practicable to reduce the risks to people's safety and ensure accurate and complete records were maintained. This placed people at risk of harm.

- Visiting healthcare professionals told us staff followed their advice and were responsive to their requests; they did not raise concerns about delay in referrals.
- We received mixed views about the quality of the food. We reviewed the four weeks of menus and found there was a lack of variety in meals offered.

Staff support: induction, training, skills and experience

- The provider did not always ensure staff had the appropriate skills and knowledge.

● Staff had not received adequate moving and handling training, they had been offered online training but had not been assessed as being competent to complete the tasks. One person told us staff were 'rough' when providing moving and handling support. We shared our concerns with the registered manager and asked them to take immediate action. On our second inspection day we confirmed most staff had received a competency assessment in this area.
● Very few staff had been offered training about maintaining people's skin integrity and there were several people living at the home who were nursed in bed and were at high risk of developing pressure ulcers. Staff had not been offered training in relation to supporting people with learning disabilities and the management of behaviours that might be challenging to others; some people living at the home required support around these areas.
● Relatives shared examples of when they felt staff did not always have the skills to meet their loved ones' needs.
● Staff had not been supported with regular supervision meetings and appraisals to ensure their performance and practice was monitored and supported. During this inspection, we found staff's practice was not always responsive to people's needs.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured staff had the qualifications, competence, skills and experience to care for people safely. This placed people at risk of harm.

● Staff told us they felt well supported in their roles by the management team.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● We found inconsistency in the application of the MCA principles.
● The provider had completed mental capacity assessments and best interest decisions for some specific decisions people required support with, but not for others.
● We found there were coded key pads in the building that could be an unnecessary restriction for some people. The registered manager told us DoLS applications had been submitted for most people living at the home.

We recommend the provider reviews how they apply the principles of the MCA to ensure people are not unlawfully restricted and all relevant assessments of their capacity are recorded.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Information about people's needs and risks was not sufficient to ensure care was delivered effectively. For example, one person who was known to have seizures had no risk assessment or care plans in place to manage this health condition. We had identified this same issue at our last inspection.

● The delivery of care did not follow best practice guidance or professional guidance given in respect of people's individual needs. For example, nutritional care and diabetes care. One person living at the service was known to display behaviours considered challenging to others and their care plans had not been designed using a positive behaviour approach where aspects such as the function of the behaviour and triggers of incidents are understood and recorded.
● The service was caring for people with a learning disability. However, the registered manager was not aware or following the guidance Right Care, Right Support, Right Culture, which sets the expectations around what health and social care providers should do to guarantee autistic people and people with a learning disability have the choices, dignity, independence and good access to local communities that most people take for granted.

Adapting service, design, decoration to meet people's needs
● Several areas of the home needed maintenance and redecorating.
● Relatives shared concerns about maintenance issues not being timely acted upon after being raised.
● The provider told us they had ongoing issues with recruiting a staff member to do maintenance work and showed us the refurbishment plan they had in place and its timeframes.

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
● People's privacy had not always been considered. We noted several people's bedroom doors were left opened but there was no evidence this was people's choice. On two occasions, we had to ask staff to assist people in order to protect their dignity.
● People did not raise concerns about this area. Relatives shared mixed views about staff respecting people's dignity. Their comments included, "Yes, staff speak respectfully and consult [relative] and tell [relative] what they will be doing such as moving [their] pillow for comfort" and "I think the permanent staff do [treat my relative with dignity and respect] but not the agency staff."
● On our first inspection visit, we saw personal and confidential information about relatives being left unattended and accessible to others who might not have the right or permission to access it. We shared these concerns with the registered manager and asked them to take action. On our second visit, we confirmed this had been rectified.
We recommend the provider reviews their practice to ensure it respects and promotes people's dignity and privacy.

Supporting people to express their views and be involved in making decisions about their care
● People were not always involved in making decisions about their care.
● We reviewed people's care plans and reviews of care and there was no evidence of people and relatives being involved.
● Relatives told us they had not been involved in reviewing their loved one's care. Their comments included, "No, I haven't been involved, I have been waiting over a year to have a daily chart of activities to be planned for [relative] and still nothing", "No [not involved in plans and reviews], not that I can remember, it was probably done when [relative] first was admitted" and "No, never."
● We asked relatives if staff listened to their loved ones and they told us, "No, not really", "Yes they do" and "Yes, but only a couple of nurses seem to listen."

Ensuring people are well treated and supported; respecting equality and diversity
● During this inspection, we observed some positive interactions between people and staff. However, we also observed staff not being responsive to people's needs and mainly focusing on the task to be completed rather than the person. For example, as one staff member approached a person to offer them a meal, they said, "Gammon or beef?". Staff did not greet the person or offer a choice of meal in a respectful manner.
● People, relatives and visiting healthcare professionals shared mostly positive feedback about staff being caring and kind. Relatives comments included, "Oh yes, all the regular staff are lovely, not so the agency

staff", "Yes, from what I have seen the staff are very kind and caring", "Yes, very much so. They talk to my [relative] in a very pleasant manner daily" and "I think so [staff are kind and caring], the majority of the staff are, I can't say the same for the agency staff though."

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 we rated this key question good. At this inspection the rating has changed to 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; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not always receive person centred care.
- We observed several people not being comfortably positioned in bed. We asked staff to take immediate action.
- Staff were not always responsive to people's needs. During our first inspection day, we heard the emergency buzzer going went off and was not being answered, therefore we asked one member of the management team to come with us to check. We noted that four staff members were in the vicinity of the room of the person requesting support and they had not responded. We observed the person who had requested assistance had been incontinent and the member of the management team had to direct staff to take action. During our second inspection day, while in one of the communal areas, we observed the shoe of a person fell off their foot and they were not able to put it back; several staff members entered the room during a period of 30 minutes and none took the initiative to support the person. We asked a staff member to take action.
- Relatives told us some staff were not responsive to people's needs. Comments included, "[My relative has a health condition and their] speech is difficult to understand because it is so quiet. Staff must take time to look at [relative's] face and give [them] time to speak but most don't. They just speak over [relative]."
- Some people's care plans lacked detail in relation to some areas of their care, their preferences and how staff should support them. For example, during our first visit, we heard a person saying, "I want to go home" and a staff member responding, "You will go tomorrow"; this does not show staff were acknowledging and actively engaging with the person to address their emotional distress. During our second visit, we observed this same person communicating in a distressed way with another resident. We reviewed this person's care plan and they did not have an emotional care plan detailing their needs and how staff should support them.
- People were not offered regular opportunities to interact or be involved in activities which were meaningful for them. Several people chose to stay in their bedrooms or spent most of the time in their bedrooms due to their health and we did not see any evidence of these people being offered regular interaction or given opportunities to develop relationships. We spoke with two staff members responsible for developing activities at the service and they told us about the 1:1 activities they developed with people, such as painting their nails and board games. However, on our second visit, one of these staff members had been allocated to kitchen duties. Relatives told us their loved ones did not have enough to do. Comments included, "Absolutely not [enough to do]", "There is no stimulation for my relative" and "My [relative] is left sitting in the lounge, even though [they are] interested in cricket, rugby and motorbikes no one engages in conversation with [them] or encourages [them] to watch these sports on [their] TV." We shared our findings

with the registered manager.

We found care was not always designed or delivered in a way that met people's needs and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● There were policies and procedures in place in relation to dealing and responding to complaints, however there had been occasions when these had not been followed. For example, concerns raised by relatives had not been recorded or responded to as a complaint. We asked to check the complaint responses issued by the provider to some relatives we knew had raised complaints, but this was not made available during or after our inspection.

● Some relatives told us they had not felt the need to make a complaint and others told us when they did make a complaint, this was not responded to by the registered manager.

● We shared our findings with the nominated individual and they told us about their plans to improve this area.

We found the provider had not always acted on feedback from relevant people in the carrying on of the regulated activity. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● Some people living at the service required palliative care. Their end of life care plans had information about the palliative care plan, although this was not always written in a person-centred way. Staff had received training in this area. We spoke with a healthcare professional who focused in supporting staff in this area and they shared positive feedback including, "[Name of registered manager] goes out of her way, in particular with relatives of people on end of life care."

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.

● The provider had developed communication care plans for some people.

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 requires improvement. 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; 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; Continuous learning and improving care

At our last inspection the provider had failed to ensure systems in place were robust enough to demonstrate risks were effectively managed, maintained securely and ensure accurate, complete and contemporaneous records in respect of each person. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We found systematic and widespread failings in the management of the service. People did not always receive safe and person-centred care. There was a significant lack of effective oversight and monitoring of the service and as a result, they had not identified risks relating to people's care, managing medicines, meeting people's nutritional needs, caring for people in a person-centred way, training and supervision of staff.
● We found the quality assurance processes in place had not been effective in identifying the issues found, for example through their medication audits and catering audits. There was a quality team and other management resources who had carried out checks and audits on behalf of the provider and these had identified some issues that continued to be found at this inspection, but timely action had not been taken to address them. During and after our inspection visits, we asked the provider for evidence of other audits conducted at the home, such as care plans, infection control, staff files, hygiene, fire safety audits, but these were not made available.
● The provider's statement of purpose was not up to date. The home was caring for people with learning disabilities and autistic traits and this was not indicated in the provider's statement or registration.
● The provider had not kept appropriate oversight of staff's training and supervision and we found several concerns about staff's practice, knowledge and skills.
● People's care plans and records of care were not always complete, accurate and contemporaneous. Relevant information gathered about people's care, such as their weights and marks found on their skin, was not fully investigated or used to inform the review of people's care needs.
● We found the staff and management team working at the home did not always work well together, or

understood their responsibilities and accountabilities.
● We found examples where the provider had not fulfilled their duty with informing CQC of incidents happening at the service.

Systems were either not in place or robust enough to demonstrate effective oversight and management of the service. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nominated individual told us about their plans to improve the oversight and management of the service, and how they were planning to allocated relevant resources. We continued in contact with the nominated individual for updates on the progress of their actions. The provider had voluntarily placed an embargo on new admissions.

● Relatives shared mixed views about the management of the service; their comments included, "'Oh, yes, it is [well manged]" "Yes, it seems to be ok" and "It is not at all well managed."
● Staff shared positive feedback about how the service was managed and about the registered manager. One staff member told us, "[Name of the registered manager] is nice and caring."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
● People's care needs were not always being met as detailed in this report and this had an impact on their safety. There was no evidence people, including people with a learning disability, were supported to access learning opportunities to promote skills acquisition.
● Relatives shared mixed views about recommending this home to others. Their comments include, "Definitely not, the home is old, bland, it needs updating. Residents need brightness, need to be cheered. Plus, it provides poor care from poor carers" "I really don't know, I haven't seen other homes to compare" "Yes, I don't see why not."
● We found warning signs of a closed culture developing at the service. CQC defines a closed culture as being as 'a poor culture that can lead to harm, including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm. Some examples of warning signs found during this inspection and reported throughout this report, include: the several safeguarding concerns about people losing weight and marks on their skin, concerns about the safety and cleanliness of the environment people live in, staff not being given the adequate training to meet people's needs, management failing to monitor and address issues raised by people or relatives, and families/relatives reporting they do not have a good working relationship with the provider.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There was varying consideration of the equality characteristics relating to the needs of people or staff. For example, the gender preference for people who received care were recorded in come care, but specific support people required due to their disability or health condition was not always explained.
● The provider told us they had sent out surveys to relatives to gather their feedback but very few had responded. We saw evidence of telephone contacts made to relatives.
● Relatives told us, "Yes, I have had a questionnaire, but I haven't completed it. I don't want my [relative] to be treated disrespectfully but haven't sent it in", "I used to get a questionnaire each year, but by phone call which can be a little uncomfortable if you have something negative to say. Now we don't even get the phone call" and "I think I have in the past."
● Staff meetings were taking place and we also saw evidence of regular communication maintained with

staff to discuss relevant aspects regarding the management of the home.

Working in partnership with others

● We saw the home had weekly visits from a GP and other healthcare professionals also visited the service on a regular basis.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care We found care was not always designed or delivered in a way that met people's needs and preferences. Regulation 9 (1) (a) (b) (c) (3) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing We found the provider had not ensured staff had the qualifications, competence, skills and experience to care for people safely. Regulation 18 (2) (a)

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found the provider failed to ensure people's safe care and treatment and failed to assess the risk of the spread of infections. Regulation 12 (2) (a) (b) (c) (g) (h)

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance We found systems in place were not robust enough to demonstrate risks were effectively managed, quality assurance processes in place were not effective and records were not always complete and contemporaneous. Regulation 17 (2) (a) (b) (c) (e)

The enforcement action we took:

We served a warning notice.