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The Elms

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

Summary of findings

Overall summary

About the service
The Elms is a residential care home providing accommodation, personal and nursing care to six people whom have learning disabilities or autistic spectrum disorder. A maximum of six people can be accommodated at the home.

People's experience of using this service and what we found
The condition of the home had deteriorated. There was evidence of leaks and damp throughout the home. There were risks to people's health and safety as fire safety procedures were unsatisfactory and regular health and safety maintenance had not been carried out as required. Accidents and incidents were not always recorded. Parts of the home were unclean and infection control had not been considered in the cellar of the home. Recruitment was not always safe. Staffing levels had not been adequately assessed.

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. A blanket ban was placed on people leaving the home without staff support during the pandemic without individually assessing people. There was one shared bathroom which gave access to bath and shower facilities for six people to access and garden area stored waste which could put people at risk. The home required an update in its décor as well as internal improvements such as fixing a hole in wall and damaged windows.

People felt frustrated as they were unable to leave the house without staff. Records in care files and daily notes reflected a lack of person-centred care and dignity with people being referred to as 'attention seeking' or 'unfragrant'. People were not involved in their care and treatment and staff did not effectively support people with their anxieties.

Care plans did not describe positive strategies to support people. Care plans did not capture goals and did not involve people and their representatives. People were not supported to undertake meaningful activities and during the pandemic, had been socially isolated as the provider had not explored safe ways of supporting people. End of Life care was not provided at the home with people being moved to other care homes, should they be at the end of their life. There had been no complaints received.

The provider and registered managers did not understand legal requirements. Lack of robust governance procedures meant little improvement was being made at the home. There was poor oversight of dignity and equality by the management team and no action had been taken following the lack of person-centred recording in people's records. The lack of oversight from the management team meant any improvements were not identified in a timely manner.

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 guidance CQC follows 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.

Right support:
Most people in the home were independent and prior to the pandemic, were able to leave the home unsupported. During the pandemic, a decision had been made by the providers to issue a blanket ban on people leaving the home without the support of staff. Individual choices had not been explored. People had limited options within the home environment. There was one communal lounge and a separate lounge which doubled up as a staff room which was not always accessible to people. There was a kitchen / diner area where people gathered to eat and watch television. The front and back gardens were unsafe and posed risks to people. Two people were sharing a bedroom where one person had no access to natural light.

Right care:
Care was not person-centred and care plans did not support people to work towards goals and they were not written in a dignified language. Peoples needs were not regularly reviewed. Where further support was required in the night, this had not been considered by the provider. There was only one bathroom which meant people had to wait for others to use the facilities. The décor of the home required further improvement to ensure it was suitable for people to reside in. People commented on the home's disrepair.

Right culture:
Staff did not treat people with dignity and respect. People were referred to as attention seeking or denied medical intervention after falls. The leadership of the home lacked oversight and did not understand how the lack of person-centred care planning and documentation did not promote people's confidence and empower their lives.

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

Rating at last inspection The last rating for this service was good (published 30 April 2019).

Why we inspected
The inspection was prompted in part due to a safeguarding concern received which may have put people living in the home at risk of harm. A decision was made for us to inspect and examine those risks.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

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

Follow up
We will request an action plan for 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

return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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?

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?

Inadequate

The service was not 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.

The Elms

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of two inspectors.

Service and service type
The Elms is a 'care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided; and both were looked at during this inspection.

The service had two managers 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. For the purpose of this report, we will refer to the managers as 'registered manager one' and registered manager two.'

Notice of inspection
We announced the inspection one hour before our arrival at the property because the service is small, and people are often out and we wanted to be sure there would be people at home to speak with us.

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 a professional who worked with the service. The professional we spoke with was unable to give any relevant feedback as they had not visited the service for some months prior to the pandemic

The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
During the inspection, we reviewed five care plans and associated risk assessments and daily notes. Three medicines records. Information relating to the health and safety of the home. Audits to monitor and improve the service, the recruitment of staff and policies and procedures to support the service. We spoke with five people who lived at the home, the registered manager, the provider, the senior carer and two care workers. We also spoke with a health and social care professional.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit 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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The provider had not ensured the home was safe and free from risks which may cause harm to people.
- The risk of fire had not been adequately assessed. The basement of the home was being used as a storage facility and contained combustible material such as cardboard, paint, continence pads, paper and wood. Overloaded electrical extension leads, and sockets were used across the home. A lead trailed under a rug which was a fire hazard. The fire risk assessment had not been completed by a competent person and did not capture the hazards we found.
- The most recent electrical installation check dated January 2020 showed findings of a potentially dangerous defect which urgent remedial action was required. At the time of inspection, the remedial action had not been undertaken.
- The annual gas safety check had not been completed. The last safety check recorded was May 2019. A new safety check was completed by the second day of inspection.
- Personal evacuation plans to evacuate people in an emergency did not describe strategies to assist people to evacuate safely and promptly. The plans had not considered there was no waking night staff and people whom were cognitively impaired may not respond to the sound of the fire alarm. There were no visual alarms to alert people to a potential fire for those who had a hearing impairment.
- A window on the first floor was not restricted and this posed a risk of falls from height. This was rectified on the second day of inspection.
- The kitchen hot tap was regularly exceeding 50 degrees and no action had been taken to prevent people from being scalded.
- Radiators were hot to touch and this had not been risk assessed which meant people were at risk of burns.
- A Legionella risk assessment wasn't in place. Health and social care providers should carry out a full risk assessment of their hot and cold water systems and ensure adequate measures are in place to control the risks.
- Risks to people were not robustly assessed. Where people presented a fall or choking risk, this had not been highlighted in their risk assessment or care plan.

Risks to people living at the home had not been appropriately assessed and mitigated. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014

Learning lessons when things go wrong

- Accidents and incidents were not always recorded. There had been three accidents recorded since 2015, however, we found three people had fallen within the last three months which had not been recorded in the accident log. There was no evidence of how people had been supported following each fall and what

strategies had been implemented to reduce the risk of further falls.

Accidents and incidents were not recorded, and learning was not gained to prevent further occurrences. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014

Staffing and recruitment
● The provider had not assessed people's dependency needs.
● One staff member worked at the home during the day and a sleep-in staff provided night cover. The provider told us local authority funding meant additional staff could not be afforded. People told us, having one staff member during the pandemic meant they could not always go out. One person's daily notes confirmed the sleeping -in staff were sending them back to bed, should they wish to get up early.
● There were no risk assessments in place to support staff who were lone working. The sleep-in staff slept on the ground floor which meant those people who were vulnerable at night, did not receive regular checks.
● Due to the staffing arrangements, it was evident people were not given freedom and choice and were unable to go out as they wished.
● Staff were not always recruited safely. There were gaps in employment records such as incomplete application forms and employment history and unverified references. Disclosure and Barring Service (DBS) checks were in place.

The provider did not deploy a sufficient number of competent staff, to make sure that they can meet people's care and treatment needs. There were no assessments in place to determine staffing levels. This is a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Preventing and controlling infection
● The home was unclean in parts and required further work to improve the standard of cleanliness.
● The basement contained one working fridge for food stuffs which was unclean. There was also a further unused fridge which stored old medicines inside that was also unclean.
● A section of the window was missing in the basement which posed a vermin risk as it led to the outside of the property.
● The staff had access to personal protective equipment (PPE) such as masks and gloves, however, registered manager one and the provider were wearing fabric masks. We spoke with them about wearing the appropriate surgical mask which was detailed in the COVID-19 PPE guidance.
● Staff told us, they had received some training in infection control, but this had not been recorded. One staff member worked across the providers two homes, thus increasing the opportunity for infection to potentially spread between the services.

Lack of regular cleaning and infection control checks meant the home was unclean in parts. Guidance in relation to infection control was not always followed. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014

● People living at the home and the staff team were part of whole home testing. There had been no outbreaks of COVID-19 at the home.

Systems and processes to safeguard people from the risk of abuse
● Staff were aware of their responsibilities to report any concerns they had. People we spoke with told us they would speak to staff or their families if they were worried about anything.
● On asking if people felt safe at the home, one person said, "It's okay here, we just don't get out much."

Another person said, "Yes, it's okay, the staff are okay."

● A safeguarding policy was in place; however, the policy had not been followed when safeguarding information had been brought to the attention of registered manager one. This meant we could not be assured the provider would share any further safeguarding allegations which may put people at risk of abuse.

Using medicines safely

● People received support to administer medicines from the staff team. Staff had not received training for the safe administration for some time and the evidence of any training could not be located. There was no evidence staff had their competency assessed to ensure they were able to administer medicines safely.

● One person was receiving their medicines covertly in food without the guidance to do so. There was no guidance recorded for staff as to which medicines were suitable to be mixed with what type of food. This potentially risked the persons medicines being ineffective. Further guidance to support the person was in place by the second day of inspection.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate.

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

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

- The home needed repair and decoration. We saw instances of damp on the stairwell which was being repaired at the time of inspection and brown stains in some rooms as a result of leaks into the property. One person said, "Look at that." While they pointed to a large brown stain in their room.
- There was damage to the bath panel, the window in a bedroom would not lock and to access the male toilet, people needed to walk via a laundry with washing drying from overhead, thus catching their head on the drying washing. There was one shared bathroom which gave access to bath and shower facilities which people told us they needed to wait to use. One room did have an en-suite bathroom, but this was out of order.
- The garden area placed people at risk of injury. There was an old glass fish tank left in the garden full of rain water. Chairs were damaged and the patio area was slippery. People used the garden area to smoke with their house mates.
- Two people shared a bedroom. For one of the people, they were in a partitioned side of the room which had no access to a window or natural day light. Natural light improves the sleep pattern and this person was known to have a disturbed sleep pattern.

The premises was not kept clean and did not have adequate facilities for the number of people using the service. This was a breach of regulation 15 (premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) 2014

- Some parts of the homes had begun a programme of decoration. One person told us they had been able to decorate their room in their favourite football team colours. People had personalised their rooms as they wished although one person was given scooby doo and Thomas the Tank Engine bedding and we were not assured this had been chosen by themselves.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People did not always have their capacity assessed.
● Where people lacked capacity, an application was not made to deprive that person of their liberty. Where any applications had been made, this was around preventing people leaving the home, unaccompanied due to the pandemic.
● Four people were prevented from carrying on with their daily lives as the provider had blanket restrictions on people leaving the home without staff support, without assessing the impact to people's health and well-being. Registered manager one told us, "The local authority had requested this and we have been told anyone going out would have to decontaminate and isolate for 14 days should they go out." There was no evidence people had been supported to see their families away from the home during the pandemic
● Where people were unable to consent to care and treatment, we saw registered manager two had consented without authorisation and without any best interests' meetings.

Where a person lacks mental capacity to make an informed decision, or give consent, the provider was not acting in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. This was a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) 2014

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Medical advice or intervention was not always sought following people receiving an injury or their health deteriorate.
● We saw examples in daily notes where people's mobility had deteriorated, or a fall had occurred, and no further action had been taken.
● One person told us, "Before the virus, I would go to my appointments alone but now I go with staff."
● People were supported to attend appointments with staff from the home. Evidence of attendance was recorded in care records.

Staff support: induction, training, skills and experience
● Staff had not received training and supervision for some time. There were no training records that could evidence recent training, although staff did tell us they had received training in donning and doffing of personal protective equipment.
● Registered Manager one told us the training and supervision has not been updated. Staff did say they had received training some time ago in health and social care related subjects, however, we could not be sure of the type of training given.
● New staff members commenced an induction when they began their employment at the home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care and support did not reflect people's needs and choices. Care was planned based upon what people could not do, rather than what they could.
● There was a lack of pro-active support for people to improve their skills. For example, one person wished

to learn how to budget money. The care plan stated, 'You have completed [a course]at college 'Shopping on a budget' which covers counting money and comparing prices, Staff have observed no improvements in this area,'

● Another person was assessed as waking up early, between 5am - 8am but since moving to The Elms they had been getting up later. The care plan stated, 'If you come down before 7.30am, staff will escort you back to bed and ensure you understand it is too early to get up.' This meant the staff were not following the persons assessed needs and not allowing choice.

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

● People were happy with the food choices and meals on offer.
● A staff member completed the weekly shopping and people were encouraged to assist in making meals
● People told us, "The food is good."

Inadequate

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity;
Supporting people to express their views and be involved in making decisions about their care

- People were not treated with compassion, dignity and respect. There was a lack of regard of people's human rights and there was a culture across the service where people were not respected as individuals and their rights were not upheld. People's personal choices were not respected or upheld,
- A recording in care plans showed one person was referred to as 'attention seeking' when they complained of headache or following a fall, one person (according to care notes) was refused any medical intervention as the provider had already supported someone to the hospital on that day.
- One person who had a cognitive impairment had thrown a tissue on the floor. Staff reported, 'Not pleased when I asked [name] to pick it up. Spent ages 'trying' to pick it up. Eventually [name] did.'
- One person told us they had been unable to walk up the road to wave at their relative at the window, there was no recorded rationale for this. Another person told us they had been unable to attend a college course due to the pandemic and they "Hated the pandemic" and "Can't wait for it to be over." There had been no further encouragement for the person to partake in a positive activity in the home to fill this void.
- There were no positive strategies recorded to support people when they became anxious about their family. In one care plan, it recorded, 'Staff talk to you about [family] but do counsel that when [family are] too busy to talk to you, it is not appropriate to mutter and swear about [family] under your breath.' There were no evidence other ways of communication such a video calls had been explored to support the person to communicate with their family.
- It was evident for one person, due to cognitive impairment, they were struggling to co-ordinate their clothing. Daily notes evidenced staff made comments on what the person was wearing and sent them back to their room to redress on a number of occasions rather than supporting the person to dress more appropriately.
- When we discussed with registered manager one about the information recorded in daily notes and care plans, they told us, it was the inspector's interpretation of the records. However, people confirmed with us, they had not been supported to see their families during the pandemic. Registered manager one also told us they had told the staff about their recording, but they don't listen. There had been no further training offered to support staff to record in a more person-centred friendly way.
- People were not supported to be involved in decision making and staff did not always recognise when people needed support.
- One person had fallen in the garden and had taken to sleeping in their chair during the night due to the back pain they were experiencing. There was no evidence staff had raised the pain with a health

professional or offer any additional pain relief. Another person was assisted to shower, and daily note evidenced the person had become distressed and was pointing to the bath. Staff continued to shower the person on another two occasions where the person continued to be distressed.

● One person was kept awake in the day by staff to assist in ensuring they slept at night. No best interests' meetings had been held to confirm if this was in the persons best interests, nor had the provider reviewed staffing levels to ensure staff could safely support the person during the night.

The provider had not made reasonable effort to provide opportunities for people to be involved in making decisions about their care and treatment. The provider had not ensured care records were written with dignity and respect. This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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

- People were not involved in planning their own care. Individual needs were not considered, and care plans were negative and lacked person-centre care. Care plans did not guide staff on current care and support needs for people living at the home. Staff failed to understand people's needs and there was a lack of understanding regarding best practice when supporting people who displayed challenging behaviour.
- Care plans contained information of what people could not do rather than promoting people's abilities and planning to improve independence in particular areas.
- People did not have positive behaviour strategies in place. Staff recordings in daily notes did not describe how they promoted positive behaviour and did not explain how they supported people who were anxious. For example, one person had not been supported to share concerns about others. The care plan stated, 'When speaking about others you are often very negative about them and keep on at other service users to agree with you. Staff suggest that if you have nothing nice to say perhaps it is best to say nothing.'
- Care plans had not been developed with people and their families and did not capture choice and control over people's lives. One person liked to ensure their bedroom was clean and tidy. People were allocated a day per week to receive staff support to clean their room. For this person, it had been recorded in the care plan, 'You think that keeping things tidy is keeping them clean, it is not. You unplug all your electricals which causes issues with re-tuning your TV and your alarm clock.' We were able to view the persons room which was extremely clean and tidy.
- Care plans did not identify strategies for people to progress to a more independent style of living and they were not regularly reviewed, the last review being over 12 months previous.
- One person told us they had been involved in their care plan and two people told us they weren't involved. This meant the care planning had not considered people's wishes and preferences.

The provider had not ensured assessments of people's care and treatment met their needs and reflected personal preferences. This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014

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

- People were not supported to develop and maintain relationships away from the home.
- It was evident the pandemic had impacted on the number of activities available to people, however, the provider had not assessed how people could continue to live a varied and fulfilled life to avoid social isolation and keep active.

● Activities in the home consisted of watching tv or people being in their bedrooms. One person played pool for long periods of time or read magazines. Staff had not supported the person to access other stimulating interests and we noted the person could be stood at the pool table without interaction from anyone.
● People told us they were restricted in what they did each day with one person saying, "We only get to walk around the park, that's it."
● People did have some visits from their family and friends arranged at the home, however, people were unable to visit the community or family alone as the provider had decided that people were unable to socially distance, without completing an individual assessment of risk.
● Registered manager one told us, arts and crafts and games were available in the kitchen, but people did not use them.

The provider had not ensured people were given opportunities to maintain their independence, explore their care and treatment to prevent social isolation. This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014

End of life care and support
● People were not supported at the home should they require end of life care.
● Registered manager one told us people would be moved to an older person's home if they were to become end of life.
● One person had a Do Not Attempt Resuscitation (DNAR) order in place by the GP which stated they were not for resuscitation. The care plan did not describe what action staff should take in the event of the person becoming seriously unwell or how staff should respond to any support required before and after the person passed. Staff said, they would call emergency services if a person became acutely unwell.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● For people who had a cognitive impairment, the provider had not ensured communication needs were assessed.
● One person whom had communication difficulties communicated using some words and gestures. Registered manager one told us, the person was tapped on their hand to enable staff to get their attention. We did not see this happen throughout the inspection and this was not recorded in the care plan. We were able to communicate effectively with the person without tapping their hand to gain their attention.

Improving care quality in response to complaints or concerns
● There was no record of any complaints being made to the provider. Registered manager one told us, no complaints had been received.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated 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

- Roles and responsibilities were not clear, and the provider and registered managers did not ensure they adhered to regulatory requirements.
- The provider had failed to report a safeguarding concern to the local authority to investigate. They carried out their own investigation and closed it down.
- The provider had not taken any action following an electrical installation report showing potentially serious defects. The provider had not ensured the health and safety of the home was continually monitored and improved.
- Of the health and safety checks completed, they did not identify all of our findings and in April 2020, a bedroom and the lounge had a leak. In the check of November 2020, both the bedroom and lounge had continued to leak, and no action have been taken to improve this.
- Audits to monitor and improve the home were ineffective and did not highlight areas for improvement. For example, on the stock count of medicines, the stock count for one medicine was wrong and no further action had been taken other than the word 'ops' written which indicated accountability of medicines was not being taken seriously.
- The provider failed to safely recruit, train and supervise staff to ensure they were suitable and sufficient to meet the needs of people living at the home. Audits did not highlight these failings.

The provider did not ensure effective systems and process were in place to assess and monitor the service. The provider did not report a safeguarding concern following the correct procedures. The provider did not support staff with training, regular supervision and to attend staff meetings. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014

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

- The service was not shaped around the needs and preferences of people that used it.
- Legal requirements were not always understood which put people's health and safety at risk.
- One of the registered managers had been away from the home for some time and felt the home had deteriorated in their absence. No action had been taken to improve the home on their return to the role.
- Operational policies and environmental risk assessments were not kept on the premises which meant staff were not familiar with the procedures.

The provider had not ensured records were accessible to staff to enable them to effectively support people and keep them safe. The provider did not ensure records relating to the management of regulated activities were available at the location and for staff to familiarise themselves with. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- The provider had sought feedback from people living in the home in September 2019 which was positive. People said they enjoyed living at the home and were supported.

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

- The provided had shared notifications with the commission about incidents which occurred at the home.

Working in partnership with others

- The provider worked with local authority provider relationship team to who monitor the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not made reasonable effort to provide opportunities for people to be involved in making decisions about their care and treatment. The provider had not ensured care records were written with dignity and respect. The provider had not ensured assessments of people's care and treatment met their needs and reflected personal preferences. The provider had not ensured people were given opportunities to maintain their independence, explore their care and treatment to prevent social isolation.

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where a person lacks mental capacity to make an informed decision, or give consent, the provider was not acting in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people living at the home had not been appropriately assessed and mitigated. Accidents and incidents were not recorded, and learning was not gained to prevent further occurrences. Guidance in relation to infection control was not always followed. Lack of regular cleaning and

	infection control checks meant the home was unclean in parts.

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises was not kept clean and did not have adequate facilities for the number of people using the service.

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure effective systems and process were in place to assess and monitor the service. The provider did not report a safeguarding concern following the correct procedures. The provider did not support staff with training, regular supervision and to attend staff meetings. • The provider had not ensured records were accessible to staff to enable them to effectively support people and keep them safe. The provider did not ensure records relating to the management of regulated activities meant anything relevant to the planning and delivery of care and treatment.

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not deploy a sufficient number of competent staff, make sure that they can meet people's care and treatment needs. There were no assessments in place to determine staffing levels.

The enforcement action we took:

NOP