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Orchard Lodge 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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Orchard Lodge Care Home is a residential care home providing personal and nursing care to nine older adults who may be living with dementia or life limiting conditions. The service can support up to 28 people. The service consists of two floors and has been adapted to support people living with dementia and physical disabilities. At the time of our inspection the first floor of the service was not being used and people were living on the ground floor.

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

People living at the service were not kept safe. Clinical decisions in areas such as pressure care were being made without a thorough assessment or referral to an appropriate professional. This put people at risk of harm. People were not being supported to live healthy lives or to see relevant health professionals in these cases. Lessons were not being learned and the service remains inadequate and in breach of regulations at this inspection.

Nursing staff and care staff members did not have the experience or knowledge to support people safely. New staff were working together when supporting people with complex needs which put both them and the people being supported at risk. Staff training was not effective and staff knowledge in areas they had been trained in was not being checked for competency by the manager or the provider. Staff were recruited safely and there were enough staff to meet people's needs.

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

Staff treated people with kindness and respect for the most part. However, on some occasions people's privacy was not maintained and people who chose to stay in their rooms had long periods of time without interaction or engagement. Staff were not supported to get to know people as individuals by the provider.

People did not always receive person centred care. People's preferences, likes and dislikes were recorded in care plans, but not always understood or used by the staff team. People were not always supported to communicate in their preferred methods. The activities coordinator at the service engaged people in several activities which people enjoyed, and this had been an improvement from our last inspection.

The manager and provider did not have effective systems in place to monitor the quality of the service. Audits were not effective in identifying where improvements could be made at the service. Whilst there had been some improvements since our last inspection, progress was slow. The provider had received ongoing support from the local authority but had been unable to sustain improvements. The continued breaches found at this inspection indicate that people are not receiving good quality care and in some cases are at

risk of harm.

People were supported safely with their medicines. The service was clean and staff followed good infection control measures. The premises were suitable to meet people's needs. People received support to eat and drink and maintain a balanced diet. People had been supported to put plans in place for the end of their life. There was a complaints policy at the service and relatives were confident that any concerns would be taken seriously.

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 inadequate (published 26 September 2019) and there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations. This is the fourth time that this service has been rated as inadequate.

Why we inspected
This was a planned inspection based on the previous rating. It was also carried out to follow up on action we told the provider to take at the last inspection.

Enforcement
We have identified breaches in relation to the safe care and treatment of people, the knowledge and training of the staff team, person centred care and the overall governance and management of the service at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan 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 therefore remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six 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 effective findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Orchard Lodge Care Home

Detailed findings

Background to this inspection

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

Inspection team
This inspection was completed by two inspectors.

Service and service type
Orchard Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 a manager who was going through the process of registering 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. The report will therefore refer to 'the manager' rather than 'the registered manager'.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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. We also reviewed the weekly action plans submitted by the provider since the last inspection, information about any reportable incidents they had sent to us, and regular feedback from the local authority about the service. We used all this information to plan our inspection.

During the inspection
We spoke with three people and three relatives about their experience of care at the service. We observed staff supporting people at the service. We also spoke with four care staff, two nurses, the cook, the activities coordinator, a domestic staff member, the manager, the provider and the provider's representative.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and four staff files in relation to supervision and training. A variety of records relating to the management of the service, including audits, policies and procedures were also reviewed.

After the inspection
The manager sent us more information for review including training information and quality assurance records. The provider sent us an action plan detailing actions they had completed immediately following our inspection.

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 inadequate. At this inspection this key question remained the same. This meant people were not safe and were at risk of avoidable har

Assessing risk, safety monitoring and management; Staffing and recruitment; Learning lessons when things go wrong

At the last inspection care plans and risk assessments were not sufficiently detailed to ensure that people were protected from harm. Staff did not always follow care plans in place. There were several issues with infection control and some medicines were not managed safely. 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

● The manager and nursing team were making clinical decisions about people's care without evidence of this being assessed for safety and risk. One person's pressure mattress had been changed without an assessment from external professionals. The manager was unable to explain who had made this decision and the reasons why the pressure mattress had been changed. A GP found that this person's pressure area had worsened and the person's original pressure mattress was not put back in to place until three days after this visit. Six days after the GP visit, this person was found to have a grade 4 pressure ulcer during a hospital visit.
● People who were nursed in bed and unable to reposition themselves were not being supported with pressure care and re-positioning regimes. There was no clinical assessment or reason for these decisions being made. Nursing staff informed us that the manager made these decisions, whilst the manager explained that nurses made these decisions. We saw no evidence that these decisions had been discussed or recorded in people's best interests. This meant that people were at risk of developing pressure ulcers or having existing pressure ulcers become worse.
● One person had a call bell which enabled them to call for support, however staff told us this person was not able to use this. We observed that this call bell was in a position that may have caused harm to the person. When we raised this with the manager, they told us that they left the call bell in case the person was able to use it. The manager then removed the call bell; however, this would not have happened without our intervention.
● We also had concerns that this person would now not be able to call for support and may have not been able to do so for some time. The manager told us that this person was now on hourly checks through the day and the night, as a result of this inspection.
● Whilst there were enough staff to support people, staff were not always deployed effectively. Staff who were new to the role, were supporting people with high support needs whilst working with other unfamiliar staff or agency members. This put people at risk of harm in areas such as moving and handling and being

supported with personal care.
● Despite there being only nine people using the service, we found that people who chose to spend time in their rooms were left for long periods of time without engagement. On several occasions one person was clearly in need of some emotional support from staff. On each of these occasions, the inspectors had to ask staff to support this person. One person told us, ''They seem to be short of staff at the moment. I stay in my room and there never seems to be anyone about. Lots of staff have just started so I do not really know much about them yet.''
● Lessons were not always learned and shared with the staff team when things went wrong. Incidents such as injuries to people were not discussed with the staff team to help inform their learning. The manager did not react swiftly where actions could have been taken following a recent incident where a person was harmed.
● Despite a lot of support from the local authority over the last 14 months, lessons were still not being learned and the service remains in breach of regulations.

These issues were a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Since our last inspection, risk assessments and care plans had been updated and contained the relevant information to help staff support people safely. We observed staff supporting people safely in areas such as moving around the service and eating and drinking.
● Plans were in place and understood by staff for emergency situations such as fire safety or extreme staff shortages and a manager was always on-call to support staff.
● The provider completed recruitment checks to help ensure that staff were suitable to work in their job roles. In some cases, necessary checks, such as employment histories were not completed fully. We informed the manager about this and they put actions in place to rectify this issue immediately.
● Despite our findings most people and relatives were happy with the staffing levels at the service and felt that their family members received the care that they needed.

Systems and processes to safeguard people from the risk of abuse
● People felt safe living at the service. One person told us, ''I feel very safe here.'' A relative said, ''I have no real concerns about safety. [Person] needs two staff to help them use the hoist and there are always two staff.''
● Staff knew how to report concerns about abuse or people's safety internally to the management team. However, staff knowledge around what abuse could look like or who to contact outside of the service was limited. The manager informed us that they would be checking staff competencies but that this would take some time. We were therefore, not assured that this would be dealt with in a timely manner.

Using medicines safely; Preventing and controlling infection
● At our last inspection, people were not always supported safely with their medicines. At this inspection we found that improvements had been made. People received safe support with their medicines and nurses were trained to administer medicines to people. Protocols were in place for people who were prescribed 'as and when required medicines' although some of these needed reviewing and updating. Audits were in place to ensure that medicines were stored and used correctly.
● At our last inspection we found several areas that presented an infection control risk. At this inspection we found that improvements had been made. The home was clean and smelled fresh. We observed domestic staff and care staff completing cleaning duties whilst wearing appropriate equipment such as gloves and aprons. One person said, ''[Staff] keep the place clean. They were hoovering and polishing this morning and do all the ironing and washing as well.''

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 inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Nursing staff and the staff team did not have the necessary skills and experience to support people safely. Training completed by the staff team was not effective as staff did not have good knowledge in areas they had been trained in such as safeguarding or the Mental Capacity Act. The effectiveness of staff training had not been checked by the management team to ensure that staff were competent in these areas.
- Staff who were new to the role were working with other unfamiliar staff or new agency staff to support people with high needs. One person sustained an injury whilst being supported by staff and agency staff who were new to the job role as a result of them being unclear as to how the person needed to be supported.
- Staff were being asked to check pressure mattresses and ensure that people were receiving safe care, however did not have training in this area. This meant that people were at risk of receiving support from staff who were not trained.
- New staff and agency staff did not receive a thorough induction in to the service. Inductions consisted of a self-assessment tool completed by the staff member who rated their own knowledge in key areas of the job role. This was followed by a brief induction in the form of a 'tick list' which covered basic areas such as a tour of the building. There was no evidence that staff knowledge or the effectiveness of the induction was being checked by the manager or the provider. This meant that people were at risk of being supported by people who did not have the skills or knowledge to support them safely.
- Nursing staff did not have a good knowledge of the people they were supporting. They informed us that they were not supporting people with catheter care or certain types of medicines, however people were receiving support in these areas.
- One person was admitted to hospital with a serious health concern. This had not been noted by the nursing team until this person's admission to hospital. Nursing staff continued to record that this person was receiving care at the service after they had been admitted to hospital. This put people at risk of harm as nursing staff were recording vital care which people needed, when they were not at the service. Records about people's care were false in this case and indicated that whilst records were completed, people were not receiving the care which they needed.
- Nursing staff were supporting people with complex needs in areas such as pressure care and bowel management. Nursing staff had received training in these areas, however their competency was not being checked to ensure that this training was effective. In one case a person had become unwell as they had not received effective care with their bowel management.

Staff did not have the skills and knowledge to support people safely and effectively. This was a breach of

Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Following our inspection, the manager sent us evidence that they had booked nursing staff on relevant training. They also sent us evidence that they would update the induction process and introduce competency checks to ensure that staff training was effective.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Clinical decisions such as changing pressure mattresses were made with no evidence of referral to other professional agencies such as tissue viability nurses. This put people at risk of receiving support which was unsafe for them. The manager was unable to explain who had made these decisions, or the reasons as to why they had been made. We asked the manager to provide this evidence on more than one occasion, however they were unable to do so.

● People at high risk of developing pressure ulcers were not being supported with pressure care management such as a repositioning regime. The manager could not provide evidence that a competent external professional had assessed people to ensure that it was safe not to support them to reposition.

● People were not always supported to live healthy lives. Our discussions with staff showed that they had a lack of knowledge about people's specific needs. People had complex health needs and were at a high risk of becoming unwell quickly. People did not have detailed risk assessments and care plans in place which would indicate the signs to show that they were deteriorating. One person had been admitted to hospital very unwell and we were not provided with records as to when or how the person had deteriorated before the admission to hospital.

● People were supported to see the GP regularly and received support from professionals such as speech and language therapists. Visits from these professionals were recorded but were not always used to inform people's care plans and risk assessments. One person told us, ''The GP comes in once a week and will sort out anything that is wrong.''

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

● Due to an existing condition on the provider's registration, no new admissions had been made to the service. Therefore, we could not follow up on the evidence we saw at the last inspection.

● People's care plans and risk assessments had been updated to be more in line with up to date care practices and standards. This included having more information recorded about people's specific preferences with regards to their care.

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

At our last inspection people were not receiving safe support to follow diets which were appropriate to their needs. Records about the support people needed were inconsistent and not always being followed by the staff team. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 14.

● People were positive about meals at the service and food looked and smelled appetising. One person said, ''The food is good, and you can eat what you want. [Cook] usually does two menus so there is always a choice of what you want to eat.''

● People who needed more support with their diet, had detailed care plans and assessments in place. Staff

supported people with the correct diet for them, which ensured that they received safe support in this area.
● The cook had a good understanding of people's dietary needs and tried to tailor menus based on people's individual likes and dislikes.
● Staff supported people to eat and drink regularly throughout the day.

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

At our last inspection some areas of the service were in disrepair and could not be used safely. Heating systems were not safe and put people at risk of harm. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15.

● The provider had made improvements to the environment since our last inspection. This included improvements to the heating systems in the service and redecoration of two bathrooms. The manager explained that work had begun to make the garden safe and desirable for people to use.
● Some signage was in place around the building to support people who lived with dementia to orientate themselves in their environment. The manger told us that they were continuing to work and improve in this area.
● The environment in the lounge and the dining room was homely and people's bedrooms had been personalised according to their likes and preferences.

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.

At our last inspection the principles of the MCA were not being followed and decisions were being made for people without following correct legal processes. Some people were being unlawfully deprived of their liberty. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

● Where people needed support to make a decision, capacity assessments and best interest decisions were made. These involved people's relatives and professionals relevant to the decisions being made.
● People who needed to have a DoLS in place, had these in place in line with legal guidelines and were being supported in line with the DoLS.
● We observed staff asking people for consent before they supported them. One person said, ''Staff are very

polite and will always ask you before they do anything.''

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 the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People were not always treated with kindness and respect. People in their bedrooms were left for large amounts of time without staff support. This included when they were visibly upset, or when sunlight was in their eyes from a window. Inspectors had to ask staff to attend to these people in these circumstances.
- The provider and manager did not always support staff to respect people as individuals. Staff training, and induction did not promote them to know people as individuals. Staff introduced people to inspectors by their wrong name during the inspection. New staff did not have a good understanding of people's specific preferences as their induction to the service had not been effective.
- We observed other occasions where staff spoke to people with compassion and kindness. Staff engaged with people in the lounge and dining room throughout the day and the level of engagement had improved following our last inspection.
- Despite our findings people were positive about their care. One person told us, ''[Staff] are very nice and kind. They are busy, but they really care.'' A relative said, ''[Staff] are caring, conscientious and loving.''

Respecting and promoting people's privacy, dignity and independence

- Staff did not always support people's privacy. A staff member held an open discussion with a person in the dining room about a health appointment which they had. Other people were in the dining room and were able to hear about this person's health conditions.
- Staff supported people to maintain their privacy and dignity in areas such as personal care. One person said, ''Staff are very polite and always knock at the door before they come in.''
- People's independence was promoted where this was appropriate, and staff told us how they would promote people's independence in areas such as personal care.

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

- People were not supported to express their views or be involved in discussing their care plans. The manager could not show us evidence of care plans being discussed with people, and their views had not been recorded. The manager told us that they were looking at ways that they could support people in this area.
- People were offered choices in their day to day care such as what to eat and whether to take part in activities.

Requires Improvement

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 requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

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

At our last inspection people were not always being supported in a person-centred manner. People were not engaged with throughout the day and people's individual likes, dislikes and preferences had not been taken in to account. This was a breach of Regulation 9 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 9.

● People's care plans now contained more information about their preferences, likes and dislikes, However, these were not always followed in practice by the staff team.
● One person was known to like watching specific television programmes and did not like listening to the radio. Throughout both days of our inspection, this person's radio was left on and their TV was covered. This showed a lack of understanding of this person's likes and preferences.
● One person had a call bell which they were to use to call for staff support. However, this person could not use the call bell. This did not meet this person's needs. We asked staff how they ensured that this person received the support that they needed. Staff informed us that they were 'always checking on [person]'. However, we observed and daily records showed, that this person went for long periods of time without staff support.
● The manager explained that they had purchased a 'shower bed' which people who were supported in bed could use to have a shower. However, this was not being used to support people. Two people had been supported to use this shower bed once over the month of February and were otherwise supported with personal care in bed. This meant that people were not being supported to try something that may have improved their quality of life.
● Staff had not been supported to get to know people as individuals. Inductions and supervisions did not focus on people's holistic needs as shown by the findings of our inspection.
● The provider had purchased two pet budgerigars which were kept in the lounge. Whilst the idea behind this was to help people engage with animals, some people did not respond well to the budgerigars and in one case this caused a person to loudly state that they were upset. One person stated that they wanted to watch TV but could not hear properly because of the noise being made by the budgerigars. We saw no evidence that the purchase of these animals had been discussed with people.
● People needs such as dementia or conditions which may affect their health did not always have sufficiently detailed care plans in place to show staff what support people may need. This meant that staff

may not be able to support people in a person-centred manner.

These issues were a continued breach of Regulation 9 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

● Despite our findings people and relatives told us staff knew them or their family member well and knew what was important to them. One relative told us, ''[Staff] know [family member] very well.''

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● At our last inspection we found that people were not engaged in meaningful activities. At this inspection we found that some improvements had been made. The activities coordinator supported people to take part in activities such as singing, hand massages, listening to audio books or using an electronic device. Staff sat and spent time with people in the lounge between care tasks to watch TV or sing with people. People seemed to enjoy these interactions.
● The activities coordinator made some effort to visit people in their rooms and see if they wanted to engage in the activities that were on offer. They were passionate about their role and were working on recording what activities people enjoyed. This was then used to tailor activities to people's specific preferences, likes and dislikes.
● People had been supported to spend time in the lounge and dining room, rather than staying in their rooms however this was inconsistent. People had been supported to access communal areas on both days of our inspection, however on the days between our visits people had stayed in their rooms. Records did not show the reasons as to why this was. This meant that people may not be regularly encouraged or engaged in the activities on offer.
● Whilst people were being supported to use the electronic device to take part in activities, some staff had not been trained to use this. This meant that they were unable to engage with people in these activities.

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.
● People were not always supported in line with the AIS. For example, we were told that pictures were used to help people make choices however, we saw no evidence of pictures being used to support people. Menus were not presented in pictorial format to help people understand the choices on offer.
● Some areas of the home had signage to help people understand where they were in the service and this was being further developed by the manager.
● Policies and procedures such as safeguarding information and a complaints procedure were available in easy-read formats for people to use if this was required.

Improving care quality in response to complaints or concerns
● People and relatives had access to a complaint's procedure. People and relatives told us they knew how to complain and were confident that any complaints would be taken seriously. One relative said, ''If you address things with the manager then they do get sorted.''
● Complaints were reviewed and responded to promptly by the manager of the service.

End of life care and support
● People had end of life care plans in place and these detailed people's wishes and preferences at this time.

- Staff had received training in how to support people with dignity and respect at the end of their lives.

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 inadequate. At this inspection this key question has remained the same. 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 there were multiple breaches of regulations, poor management oversight in the delivery of care and a lack of understanding of what constitutes a positive and person centred quality of care for people. 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.

● People continued to be at risk of unsafe care. Decisions about people's support had been made by the manager and nursing team, with no clear rationale or consideration of the impact that this could have on people. The manager was unable to explain why people were not receiving support in areas such as pressure area care.
● Audits were not effective and did not pick up on the issues identified at this inspection. The manager and the provider were not using audits to continually drive improvement. For example a known issue with the laundry room was not actioned until we pointed it out on the first day of our inspection.
● Staff were not clear about all aspects of their job roles as they did not receive an effective or thorough induction. Staff training, and knowledge was not being checked by the manager or the provider. Nursing staff did not have the training or knowledge to effectively meet people's clinical needs.
● We found evidence of falsified records which indicated that a person was still receiving care at the service whilst they were in hospital. This meant that we could not be sure that record keeping was reliable at the service. We raised our concerns about this person to the local authority safeguarding team.
● The service had been supported by the local authority for an extended period. However, despite this input, improvements were not being made or sustained and the service remains in breach of regulations. This shows a lack of continuous learning and improving care.
● The provider had sent us weekly action plans with updates about how they were continuing to improve at the service. However, the findings from this inspection show that the service is still in need of improvement. The service has been consistently rated as inadequate and in special measures since December 2018 and the provider has failed to improve the quality of care to people over this time.

● On the first day of our inspection, the manager spoke to us about an incident that had occurred the night before involving an injury to the person. The manager did not give us the full details of this incident and we received the full account of events from other organisations such as the local authority safeguarding team. This did not demonstrate a good duty of candour.

These issues were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

● Following our inspection, we immediately asked the provider to provide an action plan detailing how they would keep people safe and improve in the areas we identified at this inspection. The provider sent this to us with various actions which they would be completing to immediately improve the service.
● The manager notified the CQC and local authority safeguarding team of incidents where they were required to do so.

Working in partnership with others
● The manager and nursing team did not always link and work with other health professionals to decide how best to support people. This was the case in areas such as pressure care.
● The provider explained that they were working with the local authority to make improvements at the service, although this was a slow process.
● The activities coordinator linked with outside entertainers and local schools to arrange activities for people using the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider's weekly action plans spoke about how much the culture at the service had improved and become more positive. Whilst there had been some improvements, more work was needed to fully instil a positive and person-centred culture at the service.
● The lack of knowledge of the nursing team meant that people were not supported to achieve good outcomes.
● Despite there now only being nine people supported at the service, people who stayed in their rooms, still went for long periods of time without interaction. This meant that people were not always included in activities or empowered to take part in what was happening at the service.
● Whilst care plans and risk assessments were person-centred, the staff team did not always understand these.
● Staff were now more respectful of people's home. Staff interacted and engaged with people more positively than at our last inspection and people appeared relaxed being supported by the staff team.
● People and relatives were positive about the management of the service. One person said, ''[Management] are not doing a bad job. I am quite happy overall.'' A relative told us, ''From my point of view the service is well run. I cannot think of any major issues which bother me.''

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were involved in making decisions about some aspects of the service such as meal planning. One person said, ''[Management] sometimes come around and ask how things are going.'' However, we saw no evidence where feedback collected from people, had been used to put actions in place to improve the service.
● Relatives were invited to give feedback about the service on a regular basis.
● Staff told us that they attended staff meetings, where decisions made about the service were discussed

with them.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving person-centred care and staff members did not have sufficient knowledge of people's preferences, likes and dislikes,.

The enforcement action we took:

Enforcement action already in place and ongoing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Clinical decisions about people's care were being made without referral to relevant health professionals and with no clear rationale for the decision. Nursing staff did not have the skills and knowledge to meet people's complex health needs.

The enforcement action we took:

Varied a condition on the providers Notice of Decision to stop people coming back to the service if they have been admitted to hospital.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The manager and provider did not have a good oversight at the service. Audits were not effective at identifying actions to take and there had been a failure to make and sustain improvements at the service.

The enforcement action we took:

Enforcement action already in place and ongoing.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Staff did not have the skills and knowledge to support people safely and effectively.

The enforcement action we took:

Enforcement action already in place and ongoing.