ADR Care Homes Limited

Hill House

Inspection report

High Street
Ellington
Huntingdon
Cambridgeshire
PE28 0AG

Tel: 01480890324
Website: www.adrcare.co.uk

Date of inspection visit:
22 February 2023
09 March 2023
22 March 2023

Date of publication:
05 June 2023

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
Hill House is a 'care home' providing personal care up to a maximum of 37 people. The service provides care for younger and older adults, some of whom live with dementia, in one adapted building. There were 25 people living in the home on the first day of our inspection, 23 on the second, and 22 people thereafter.

People's experience of using this service and what we found
The service was not well-led. The provider had failed to carry out their regulatory responsibilities. They did not have effective quality monitoring procedures in place to identify shortfalls and drive improvements in the service people received. This exposed people to significant risk of harm. The provider failed to deliver safe, person-centred care and had not made improvements they said they would make.

The provider did not safeguard or protect people from harm. They had not referred all potential safeguarding events to the local authority in line with protocols. Staff did not ensure people received care and treatment in a safe and effective way. We found multiple failures in the safe use of medicines.

Risks to people's safety were not fully assessed or reduced. Staff did not support people to move safely. Systems were not followed to help maintain people's skin condition. Staff did not follow the provider's policy in relation to falls, and emergency healthcare was not sought promptly in line with this. Fire related risks were not well-managed, people had access to substances hazardous to their health, and the home was not clean nor well-maintained. This placed people at risk of harm.

The provider's systems did not enable staff to effectively identify and manage people's dietary needs. This put people at risk of not receiving sufficient or appropriate food and fluids.

People's care needs were not effectively assessed or reviewed and care was not planned in line with best practice guidance. Care plans were contradictory and not updated to reflect people's changing needs. They did not contain enough personalised information to support staff to respond to people's needs safely and effectively. Gaps in care records meant we could not be assured care had been carried out as planned.

Staff had not received effective training or regular supervision. This resulted in staff not having the skills to meet people's needs and we found multiple areas of poor practice.

People were not always treated with dignity and respect. We saw many missed opportunities for people to be involved in decisions about their care. Opportunities for people to be involved in social engagement and activities were limited. People were not consistently 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 support this practice.

People liked the food and the staff. Some staff interacted with people in a kind and caring way. Relatives

told us they felt involved in their family member's care, and staff kept them up to date if anything changed.

The nominated individual was receptive to our findings and suggestions. They stated a commitment to improving the service through greater oversight and governance to ensure people received safe care that met their needs and wishes. They had started to implement new quality audits during our inspection. However, these needed time to be implemented and to become embedded in practice.

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 (report published 30 May 2018).

Why we inspected
The inspection was prompted in part due to concerns about safeguarding people from harm, safe care, staff training and support, nutrition and hydration, person-centred care, privacy and dignity, poor maintenance and cleanliness, and good governance. We reviewed of the information we held about this service. A decision was made for us to inspect and examine those risks.

We found evidence during this inspection that people were at risk of harm from these concerns. Please see the safe, effective, caring, responsive and well-led sections of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations
We have identified breaches in relation to safeguarding people from abuse, safe care and treatment, staffing, nutrition and hydration, person-centred care, premises and equipment, consent, dignity and respect, and good governance at this inspection

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

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 always safe. Details are in our effective findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
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**

Hill House

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Hill House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Hill House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The nominated individual had submitted an application to register with CQC. We are currently assessing this application.

Notice of inspection
This inspection was unannounced. Inspection activity started on 22 February 2023 and ended on 3 April

2023. We visited the home on 22 February, 9 March, and 22 March 2023.

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 commissioners of the service. We used information gathered as part of a monitoring activity completed on 8 February 2023 to help plan the inspection and inform our judgements. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During our visits we used observations to help us understand the experience of people who could not talk with us. We spoke with 5 people who received the service, and 5 of their relatives. We received feedback from 4 external professional who had contact with the service. These included the local authority, a GP, a Fire Safety Inspector, and a trainer. We spoke with 12 members of staff. These included care staff, agency staff, senior care staff, catering, domestic and maintenance staff. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. These included sampling 9 people's care records, multiple medication records, and 3 staff files in relation to recruitment checks. We also looked at a variety of records relating to the management of the service, including staff rotas and training records, meeting minutes, audits, quality assurance reports, and action plans.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not adequately protected from the risk of harm. The provider had failed to refer all potential safeguarding events to the local authority in line with the local authority's protocols. For example, we found the provider had failed to report an allegation of physical abuse to the local authority and had not taken any action to safeguard the person, or other people, from harm until we raised this with them. The provider gave us assurances after the first visit that a new system would be implemented immediately that would ensure any safeguarding concerns were reported appropriately.
- Despite assurance from the provider, we found the system implemented was not safe or effective. During our second visit we found staff did not show a good understanding of safeguarding processes. Whilst most staff had received safeguarding training, some staff were not able to describe what may constitute potential safeguarding concerns and they did not recognise, or report, such incidents when they happened. This included the nominated individual. During the course of this inspection, we raised 10 safeguarding referrals to the local authority to keep people safe.
- The local authority shared with us a further nine potential incidents which the provider failed to report to the local authority in the previous four weeks.

The provider had failed to establish and implement systems to ensure people were effectively safeguarded from abuse. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- The provider failed to manage medicines safely. Staff were unable to explain discrepancies in people's medicine stocks and this had not been identified through medicine audits. This meant people may have been at an increased risk of harm. Staff had received medicines training and had their competency to administer medicines checked. However, the training had not been effective. Records had not always been completed accurately. Staff told us although they signed to show they had witnessed some medicines being administered, they had not been present.
- Night staff had not been trained to administer medicines. Staff told us people either received their night medicines earlier than prescribed, or they were left with untrained staff to administer. If people needed medicines during the night, a staff member told us they would call a senior staff member. This meant, had people needed medicines, such as pain relief, there was a delay in receiving them. This put people at increased risk of unnecessary harm or discomfort.
- People did not always receive their medicines as prescribed. Where medicines were administered through patches applied to the person's skin, systems were not followed to ensure the site of administration was rotated and the previous patch removed. This may have affected the absorption rate of the medicine,

placing people at risk of overdose.
● Staff told us although they had signed to show they administered prescribed creams, these were sometimes administered by other staff.
● People were prescribed 'when required' or 'as directed' medicines. We found guidance was not available for staff to ensure medicines were safely administered.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to people's safety were not fully assessed or reduced. This placed people at an increased risk of harm. Risk assessments were not detailed enough to give staff guidance on how to lower risk or support people safely. For example, there were gaps in information in risk assessments regarding people's mobility, falls, skin care, and distressed behaviour. In addition, the provider failed to promote a safe environment as people had access to substances which could be hazardous to their health such as cleaning products.
● Staff did not always support people to move safely or use appropriate equipment to assist people. During the first day of our inspection, we saw 2 staff members use inappropriate equipment to help people move around the home. A third staff member told us another person sometimes needed help to move using a hoist. This was not reflected in the person's care plan. They went on to tell us that the person did not have the right size sling to safely move them and told us the person had "almost come out" of the sling two days earlier. This placed the people and the staff members at risk of serious injury.
● The provider failed to ensure systems were followed to help people maintain the condition of their skin. For example, one person was being treated by the district nurse for a pressure wound. However, the person's care plan did not reflect this but said they were "on a repositioning chart". There was no guidance for staff on how often the person should be supported to reposition.
● Staff did not always follow the provider's policy in relation to falls. For example, staff told us a person had an unwitnessed fall and a head injury. However, they had not called 999 as directed by the provider's policy. Staff sought medical advice and carried out observations after we prompted for this.
● Fire-related risks were not always well managed. We found many fire doors propped open with furniture and other objects. These prevented the doors automatically closing in the event of a fire. We also found doors unlocked and open that had notices on them instructing they should be kept shut and locked. This meant there were increased fire-related risks to people. The provider gave us assurance these matters would be addressed after the first day of our inspection. However, when we returned on the second day, we found their measures had not been effective and again multiple fire doors were propped open.
● We found multiple missed opportunities for lessons learned. Accident and incident forms were designed to prompt the provider to reflect on lessons learnt. However, these had not always been completed to aid learning. Action was not always taken in a timely manner to ensure when improvements were needed these worked in practice. For example, not all important information was available for staff regarding people needs even though this had been fed back after the first day of the inspection.

Preventing and controlling infection
● The provider failed to ensure people were protected from the spread of infection.
● The provider demonstrated they made significant improvements following an external IPC expert's visit to the home the day before our first visit. Despite this, we found multiple areas of the service were visibly dirty and damaged, making them difficult to clean. This included furniture, paintwork, and sealant used for flooring and grouting in bathrooms. Furthermore, equipment, toilet surrounds and clothing rails were in a poor condition. The provider employed only one member of staff for domestic duties, and care staff were expected to cover when they were on leave. Domestic staff said they had been told by an external IPC professional to use chlorine-based products to clean floors. However, they told us they did not always use this and used an alternative product. The cleanliness of the building suggested this was not sufficient to support safe infection prevention and control practices and put people at the risk of harm from

communicable illnesses.
● Staff were confused about people's covid status during an outbreak. A staff member told us some people living at the home were still Covid positive and indicated a record of people's Covid status. However, another told us everyone had tested negative.

● We were also therefore not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were not assured that the provider's infection prevention and control policy was implemented effectively. The senior staff member on duty could not remember having seen a Covid risk assessment.

The provider had failed to manage medicines safely and robustly assess the risks relating to people's health, safety, and welfare. This put people at risk of harm. The provider did not have effective infection control procedures and failed to provide a clean and safe environment to protect people from the risk of infections. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment
● People and relatives told us there were enough care staff and staff responded to call-bells. One relative said, "[Staff] are always busy, but they always speak to [my family member] as they go by." They confirmed staff responded promptly when the person used their call-bell.
● The provider assessed people's needs to identify how many care staff were needed in the home. However, the nominated individual said they also assessed how busy staff were, and when people received personal care to help them assess staffing numbers.
● Although there were sufficient care staff they were not always deployed to ensure people's safety. The nominated individual told us that one person needed staff to be with them in communal areas to keep them safe. However, we saw they were unsupervised on several occasions during this inspection.
● The provider only employed one domestic worker who worked 6am-2pm, with the maintenance staff providing some support to them. Some care staff also did extra shifts cleaning the home. Prior to our inspection the home had received support from an infection prevention and control nurse from the local authority. They had identified multiple shortfalls and recommended additional domestic support. Some improvements had been made when we inspected, and the nominated individual told us that care staff were working additional hours to support cleaning the building.
● The provider followed some safe recruitment processes, including obtaining a check of criminal records and references, to ensure staff were of good character. However, there was no evidence they had explored gaps in staff member's employment.

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People did not receive effective care. Risk assessments and care plans were not updated to reflect people's changing needs or preferences. Care plans did not include sufficient personalised information to guide staff to help them meet people's needs effectively. For example, one person's care plan did not include the information that they sometimes needed to be hoisted or the equipment that was needed.
- An external healthcare professional said staff did make an effort to support people to follow any advice they gave. However, there had been occasions when this had not happened, and their request for specific actions had been delayed. During our inspection, staff did not act promptly when requested to obtain a specimen. This meant any treatment needed may have been delayed.
- Care records were contradictory and inaccurate and did not provide assurances staff were always delivering care in line with people's assessed needs.

The provider had not ensured people's care was appropriate and met their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider's systems did not enable staff to effectively identify and manage people's known dietary needs. A person's care plan did not include that the person had a health condition which was controlled by diet. Staff preparing food were not aware of this person's dietary needs. Staff told us they regularly gave 4 people with this dietary need food that was not suitable for them. This put people at risk of not receiving effective care because they were not supported to receive a suitable diet.
- People did not receive food and drink when they requested it. 10 people were up in the lounges at 6.30am. However, they could not have breakfast or a hot drink until staff came on duty at 8am. 3 people told us they had been up since 5am. We heard 2 people call out to staff, "I want my breakfast." Staff told them to wait until 8am. 3 people confirmed they were hungry and 1 person said they were, "Starving". They told us, "Sometime ago [a manager] said we could [have breakfast earlier] but nothing came of it."
- Staff did not always encourage people to eat and support them to have good posture while eating. We saw a person was slouched low in their chair. 2 staff separately attempted to assist the person to eat until we questioned this. People were left for long periods, allowing their food to get cold, before staff offered to help them. One person walked away after their first course, staff did not encourage them back to the table and they didn't have dessert.

● Records relating to people's food intake were inconsistent and did not guide staff in how to support them. For example, staff told us a person always drank using a cup with a spout, but this was not recorded in their care plan. Another person's care plan stated they could eat independently, but their care notes, and our observations, did not support this.

The provider had not established systems to ensure people were consistently supported to receive adequate diet and fluids in line with their nutrition and hydration needs. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they liked the food. One relative said their family member particularly liked the fruit salad snack, describing it as, "A big hit."

Staff support: induction, training, skills and experience
● The provider had failed to ensure staff received effective training and we found poor practice in areas such as safeguarding, moving and handling, and medicines management. Staff had not received training in relation to people's needs and health conditions. For example, tissue viability, end of life care, and Parkinson's Disease. This increased the risk of staff not having the skills to meet people's individual needs effectively.
● Senior staff received an induction when they were first employed at the service. However, they did not receive an induction when they were promoted into new roles within the senior team. The lack of induction meant staff did not always know and understand their responsibilities or the provider's systems. For example, in relation to safeguarding and medication management.
● The provider had not followed their own policy and ensured staff received regular supervision at least six times a year. 4 care staff last received supervision 5 months previously. None of the ancillary staff had received supervision in the last 7 months. The nominated individual told us the supervisor was a finance manager, and these were "welfare" supervisions. This meant people were receiving care from staff who had not been supported to develop or improve their professional practice.

The provider did not ensure all staff were sufficiently trained and supervised. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One staff member described their recent induction. They said they were "introduced to [people], shown around, shown equipment and how to use it, and given an overview of what to do." The provider showed us they were in the process of implementing a new induction process for senior staff.

Adapting service, design, decoration to meet people's needs
● The building was in need of updating and considerable maintenance work. A relative told us, "The building is very run down." All 4 relatives' responses to the provider's survey commented negatively on the condition of the building. We saw damaged flooring, furniture, and sealant and grout; rotten window frames; chipped and scuffed paintwork; and water damage.
● The environment did not support people who were living with dementia to orientate themselves within the service. For example, there was not adequate signage for people to access toilets independently or to identify their bedrooms and some corridors were poorly lit.
● Maintenance was not carried out at times, or in a way best suited to people living at the home. During our inspection a hallway in a very busy part of the home was being painted. We saw people having to navigate around the person who was painting. There were no 'wet paint' signs displayed, and we saw one person got paint on their clothes.

The provider did not ensure the premises were sufficiently maintained or suitable for people with dementia. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Maintenance work was ongoing at the service. A relative told us their family member's room had been decorated before they moved in and damage caused by the hoist had been repaired quickly and action taken to reduce the risk of the damage happening again.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Care homes must comply with any conditions set by the supervisory body who authorise DoLS applications. The nominated individual told us 2 people had conditions attached to their DoLS authorisations. The provider had not followed one person's condition to arrange a referral for the person's medicine to be reviewed. The nominated individual could not tell us if a second person's condition to arrange a referral to a memory clinic had been done. We found a third person also had a condition attached to their authorisation which the nominated individual was not aware of and did not know whether the condition had been met.
● We found people were not always involved in decision about their care. For example, when they had their meals.

The provider did not ensure people had maximum control over their lives and did not always adhere to conditions set in people's DoLS authorisations. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had systems in place to assess, review and report on people's mental capacity and decision-making abilities. Some people had mental capacity assessments in place. However, the decision would benefit from being clearer.
● Staff had received training in the MCA. Senior staff were aware of who had a DoLS authorisation in place.

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 our last inspection we rated this key question good. At this inspection the rating has changed to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence;

- People were not always treated with respect. Systems to keep people safe from harm and protect them from risk were not always in place or followed. For example, there were shortfalls regarding medicines management, moving and handling, and building maintenance. People's care plans were contradictory and did not contain enough information to ensure staff would meet the person's needs effectively.
- We saw people who were unable to express a preference sitting in the lounge in their night clothes asleep from 4pm. When we asked staff why people were assisted into their night clothes so early, they said, "because we have always done it." Staff described another person as going to bed at around 6pm and is then woken at about 4am. Again, the staff member did not know why this happened. Staff told us they were expected to help 10-12 people to get up before day staff arrived at 8am. We saw many of these people asleep in their armchairs while waiting for breakfast.
- We saw many missed opportunities for people to be involved in decisions about their care. For example, menus were not displayed, and no pictures of the foods on offer were available. People were not offered a choice of drinks, and 2 of the 3 tables in the dining room did not have condiments on them. There were missed opportunities for social interactions, with staff often putting people's food in front of them or clearing away plates without explaining what the food was or speaking with them. We saw staff lift a person's legs, so their feet were on wheelchair footplates. The staff member didn't say anything to the person and the person screamed out.
- We heard staff refer to people's health conditions in front of other people. Boxes of people's personal care records were stored on a landing and care records were left unattended in lounges with other people present. This did not respect people's privacy, dignity or confidentiality.

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

- Staff didn't always offer prompt or offer appropriate assistance. During a meal a person was repeatedly calling out. Whilst staff sometimes responded, and the person calmed somewhat, staff often ignored the person and continued with what they were doing. We saw another person pick up a whole sausage with their fingers and bite it. When prompted, staff cut it up. A plate-guard was on upside down and food was falling off the person's plate. We saw 2 staff helping a person to eat whilst standing beside them. Another staff member had an personal conversation on the telephone about another person whilst continuing to help the person to eat. These missed opportunities did not promote people's dignity.
- The lunchtime meal was chaotic and prolonged. In one lounge a person received their meal 45 minutes after the first person received theirs. Another person asked twice when they would have something to eat

before staff supported them to lunch, almost 20 minutes after their neighbour was served their food. In another room a person asked 3 times before staff supported them to have dessert. This did not show people were respected. Some people were up for 3 hours before they could have breakfast or a hot drink.

The provider had not ensured people were treated with dignity and respect or their independence promoted. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they liked the staff. One person said, "The staff are nice." Another person described specific staff as, "Lovely," identifying their favourites. A relative told us, "The [staff] themselves are really lovely. They are all really helpful. They are always happy and jolly with my [family member]. They chat with [my family member] on [their] level."
● During our inspection we saw some staff interacting with kindness and in a caring way with people. An external care professional described staff as, "Very caring."
● Relatives told us they felt involved in their family member's care and staff kept them up to date if anything changed. A relative said, "[Staff] keep me up to date with everything."

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; End of life care and support;

- The provider failed to ensure people received care and support that was personalised and responsive to meet their needs. Staff did not always engage with people in a positive way. Throughout the inspection care provision was task and routine led, and not person-centred.
- People's care plans and risk assessments contained conflicting information and were not always up to date or reflective of their current needs. This included the information about dietary needs, their skin integrity, and mobility. This meant that relevant information was not captured for use by care staff and external professionals. Nor did it supply enough information to show people were receiving appropriate care. For example, staff were not aware that one person was diabetic. This placed the person at risk of illness as they were not being supported to have an appropriate diet.
- Some staff told us they had not read people's care plans and relied on information handed over from other staff. The provider put in place a "service user information sheet" which supplied key information about each person's needs. The nominated individual told us this would help ensure people received continuity of care. However, we found staff did not always have access to this.
- Although the service did not offer specialist end of life care, it did support people already living there who were approaching the end of their life. Staff did this with support from external health professionals, such as district nurses. However, none of the staff had received any end of life training. This meant people's needs may not be effectively met by staff.

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

- Activities of interest, and social occasions were not planned, displayed nor co-ordinated by a dedicated member of staff. This meant people did not benefit from a varied activities programme.
- Staff told us the activities available on the first day of our inspection were, "A couple of games, couple of showers." Staff spent time in one lounge with people playing a board game, and with one person colouring. We did not see staff support any other activities or pastimes. Televisions were on in both lounges, but we rarely saw people watching these or heard staff consult people about the programmes. Care plans did not support staff to engage people in meaningful pastimes. One person's care plan said they, "did not join in activities." It gave no guidance on how to engage with the person or spend meaningful time with them. A staff member said they recognised that people were bored, and this may increase a person's risk of falls.

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 nominated individual told us that they would supply documentation in alternative formats, if these were requested. However, with the exception of the provider's complaints procedure in large print, there was no information in accessible formats for people. Improvements are needed to display signage and ensure people have access to information on areas such as advocacy.

The provider had not ensured people's care and treatment was person-centred. People's care plans were not personalised and did not reflect their needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives told us people's hygiene needs were met. One relative said their family member was, "Always clean and tidy." They said their "things" and hair looked nice and staff helped them with this.
● Relatives told us staff informed them of any changes in their family members well-being. One relative said staff were, "Very supportive and valued families." They said staff realised their family member liked the familiarity of their relative's company. Another relative said they felt welcomed into the home.
● Care plans contained basic information about people's communication needs, such as whether they needed any aids to help them communicate.
● Some people were encouraged to pursue pastimes they had enjoyed previously. A relative told us staff had encouraged and enabled their family member to participate in a handicraft they had enjoyed for much of their life. Some people participated in a church service that had recently been held in the home.

Improving care quality in response to complaints or concerns
● The provider told us they had a complaints procedure. The provider's record of complaints did not show all the concerns received.
● Where the provider had documented a complaint received and their response, they could not show us any record of their investigation, or how they had reached their conclusions. The provider had recorded lessons learned but these did not cover all the identified issues.
● Relatives knew how to complain and told us actions were taken to bring about improvement when they raised concerns.

Inadequate

Is the service well-led?

Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others

● The provider had failed to establish and implement effective governance systems to monitor and improve the quality of the service. Although some audits were completed these had failed to identify the concerns we found during the inspection. We found serious shortfalls in relation to safeguarding people from harm, moving and handling, medicines management, identifying and responding to people's healthcare conditions, and the provision of food and fluids. Systems and processes to identify risk and to help keep people safe, were not robust. Staff training and supervision was not effective. The provider had not identified or responded to these concerns prior to our inspection or local authority involvement. There had been a lack of managerial leadership and guidance to ensure people's health and care needs were assessed, reviewed and effectively met.

● The provider had failed to learn when things went wrong. The provider responded quickly when we raised serious concerns. They described the improvements they had put in place and further actions they planned to take to improve the quality of the service. Despite this, we found the provider did not effectively implement their action plans, and sufficiently monitor improvements were being made or sustained.

● The provider had not recorded all concerns received. They could not evidence robust investigation into a complaint raised and the recorded lessons learned did not cover all the identified issues.

● Records were not consistently accurate, up to date, or available. These included people's care records, and records of who was in the service at any time. People's records and CCTV recordings were not always kept securely and in line with the provider's policy. We could not always rely on the accuracy of the information the provider gave us. For example, the provider told us there had been no safeguarding concerns between our second and third inspection visit. However, we found this was not the case and made 6 referrals to the local authority safeguarding team that the provider should have made during that time.

● The provider had not always worked in partnership and effectively communicated with external organisations. For example, they had failed to make referrals to the local authority safeguarding team. This put people at risk of harm and poor care.

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 provider had not always understood the requirements of the duty of candour, ensuring they were honest and open about any incident or accident that had caused or placed a person at risk of harm.

● Concerns, incidents and accidents were not always reviewed. Incidents raised with the provider had not

always been investigated and any necessary action taken to prevent it happening again. Information had not always been shared with people in response to incidents.

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

● There were limited formal processes were in place for gathering information from people and their relatives. No meetings had taken place to gain peoples' or relatives' views. The provider sought feedback from relatives via telephone surveys. However, where issues were raised there was no evidence of follow up. For example, all 4 relatives commented on the poor cleanliness and décor. However, the provider took no action until these concerns were raised by external professionals.

● Only one staff meeting had taken place in the previous 9 months, in December 2022. Staff had not received supervision in line with the provider's policy. The provider had not sent satisfaction surveys to gain staff feedback. Staff were not aware of new systems implemented by the provider which left people at continued risk of harm and poor outcomes.

The provider had not ensured systems to monitor and improve the quality of the service were effective which meant people were receiving a poor service. The provider had failed to ensure records were accurate, up to date, legible, or available. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The previous registered manager cancelled their registration with CQC in December 2022. A new manager was appointed, but had not applied to register, and left in January 2023. The nominated individual had managed the service since and immediately applied to CQC to register as manager. CQC was assessing their application at the time of this inspection.

● The nominated individual was receptive to our findings and suggestions. They stated a commitment to developing the service to enable greater oversight and governance, and to ensure people received safe care. They had started to implement new quality audits during our inspection. However, these needed time for full implementation and to embed in practice. The nominated individual told us they were involving external professionals for advice and support and provided us with action plans to make some of the required improvements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people's care was appropriate and met their individual needs

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people were treated with dignity and respect or their independence promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure people had maximum control over their lives and did not always adhere to conditions set in people's DoLS authorisations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure all staff were sufficiently trained.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to manage medicines safely and robustly assess the risks relating to people's health, safety, and welfare. This put people at risk of harm. The provider did not have effective infection control procedures, and failed to provide a clean and safe to protect people from the risk of infections.

The enforcement action we took:

We served an urgent Notice of Decision to impose conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to establish and implement systems to ensure people were effectively safeguarded from abuse.

The enforcement action we took:

We issued a warning notice to ensure the provider made the required improvements and people were safeguarded from harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not established systems to ensure people were consistently supported to receive adequate diet and fluids in line with their nutrition and hydration needs.

The enforcement action we took:

We issued a warning notice to ensure the provider made the required improvements and people received sufficient and appropriate food and fluids.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not ensure the premises were sufficiently maintained or suitable for people with dementia.

The enforcement action we took:

We issued a warning notice to ensure the provider made the required improvements to the premises.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured systems to monitor and improve the quality of the service were effective which meant people were receiving a poor service. The provider had failed to ensure records were accurate, up to date, legible, or available.

The enforcement action we took:

We served an urgent Notice of Decision to impose conditions on the providers registration.