Lincoln House Care Home Ltd

Lincoln House Care Home

Inspection report

Woodgate Lane
Swanton Morley
Dereham
Norfolk
NR20 4LT

Tel: 01362637598

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
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
Lincoln House care Home is a residential care home providing personal and nursing care to 53 people including seven who were receiving respite care at the time of the inspection. The service can support up to 60 people.

The service is split into a nursing unit and a residential unit in one purpose-built building.

People's experience of using this service and what we found
Risks, including those relating to the environment, were not well managed. Some risks had not been sufficiently assessed and mitigated and placed people at risk of harm. Some safeguarding incidents had not been appropriately reported and investigated to see if lessons could be learned to avoid a repeat occurrence. Medicines were mostly well managed, but some risks associated with particular medicines had not been fully assessed. Infection prevention and control measures were good.

There were not always enough staff to meet people's needs on the residential unit. There was a reliance on agency staff who did not always have the skills needed to provide quality support. Permanent staff, although trained, did not always demonstrate an understanding of people's needs and health conditions. The environment was not always safe or suitable to meet people's needs. Environmental risks had not been clearly identified and mitigated in the provider's auditing processes. Monitoring of people's food and fluid requirements on the residential unit was poor and placed people at risk of not having enough to drink.

Records relating to some people's capacity to consent to their care and treatment showed they were not supported to have maximum choice and control of their lives; the policies and systems in the service did not support this practice.

Staff were caring and kind and people who used the service praised their dedication and patience. Staff were busy and sometimes struggled to spend time with people. There had been limited engagement with people about their views on the service. New surveys had been devised to seek feedback from people about key aspects of the service.

Pre-admission assessments were not fully completed for all people who used the service. This risked people's needs not being met safely. People had the opportunity to review their care needs with staff but sometimes their preferences, although recorded, were not respected. A new care planning system was about to be introduced which had been designed to improve all aspects of care planning and recording. People's end of life care was well managed and people's wishes clearly documented. Complaints were well managed.

Oversight of the service at all management levels, including regional oversight, was poor. Systems to assess, monitor and mitigate risks to people's health, safety and welfare were not fit for purpose and placed people

at risk of harm. The provider has acknowledged this and introduced new systems and made changes to staff deployment to begin to address the serious failings we found.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 7 June 2019.) 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.

Why we inspected
The inspection was prompted in part by notification of a specific incident, following which a person using the service died. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of risks relating to people who leave the service when it is unsafe for them to do so. This inspection examined those risks as part of a comprehensive inspection process.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Following the incident which prompted this inspection, the provider took immediate action to begin improving the security of the service by fitting alarms to external doors and carrying out a full review of the security of the environment. They also began to address our concerns relating to safety as soon as we raised them by removing items which could be choking, ingestion or scalding risks and by closing off the courtyard until remedial works were completed. These actions have mitigated these risks.

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.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to assessing people's needs, consent, safeguarding, risk management, safety of premises, staffing, governance and failure to make appropriate notifications to CQC at this inspection. Please see the action we have told the provider to take at the end of this report.

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 the provider sends us their service development plan outlining what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Lincoln House 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.

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
This inspection was carried out by three inspectors on 22 June 2021 and one inspector for a further day on 23 June 2021. One inspector carried out a feedback session following the conclusion of the inspection process on 13 July 2021.

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority quality monitoring and safeguarding teams. 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 used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service, three care staff, four senior care staff including enhanced seniors who had additional responsibilities, the head of residential care, one nurse, the clinical lead who was also the deputy manager, the cook, two members of domestic staff, the managing director, a regional manager, the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with a consultant psychiatrist who was visiting the service to carry out an assessment.

We reviewed a range of records. This included nine people's care plans and five people's medication administration records. We looked at two staff recruitment files and the induction record for one agency staff member. We also reviewed a variety of records relating to the safety and quality of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider failed to ensure sufficient numbers of suitably qualified, skilled, competent and experienced staff were deployed. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. An action plan was drawn up outlining how the provider would bring about the improvements needed. At this inspection we found that enough improvement had not been made and the provider remains in breach of this regulation.

●There were not enough skilled and experienced staff to meet people's needs.

Staffing and recruitment

●Staffing levels were determined in line with a dependency tool which assessed each person's staffing needs. Rotas were not accurate documents which meant it was difficult for us to determine if staffing was always provided in line with people's requirements, especially where one to one staffing was in place.

●The service relied heavily on agency staff at times, especially at night. Staff on the residential unit told us they felt that some agency staff were not skilled enough to carry out their roles. This meant that although staffing numbers were increased on a shift, permanent staff were still under pressure.

● We received negative feedback about staffing from people who used the service and from staff. Some people told us they had to wait too long for their care needs to be met. One person commented, "Staff are nice but always very busy, especially at night". Another person expressed that they would like to go outside into the courtyard but this required a lot of staff support and so they had stopped asking.

● A staff member on the residential unit said staffing levels had been "Horrendous for a long time. We have to prioritise." They went on to explain that people who required two staff to hoist them sometimes apologised to staff as they were aware that they took up a lot of staff time. All the staff we spoke with on the residential unit felt that there were not enough staff.

● We observed one person on the residential unit waiting 35 minutes to be supported to get up in the morning. They told us they ideally liked to be up by 11am but were still waiting for staff to support them at 12.09. Another person told us they had waited over an hour for support to use the commode. A third commented that they were not able to have a shower and were supported to have a wash instead as this was quicker. We noted an entry in one person's records instructing staff to nurse them in bed that day due to a shortage of staff.

There were not enough staff skilled and experienced staff to meet people's needs promptly. The service was a repeated breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff and people who used the service acknowledged that additional pressures had been placed on staffing by the need to manage visiting and arrange additional testing for COVID-19. A good system was in

place which was designed to relieve pressure on staff.
● Staff were safely recruited using a robust recruitment procedure.

Systems and processes to safeguard people from the risk of abuse;
● Systems designed to safeguard people from the risk of abuse or improper treatment were not robust. One person had left the service on three occasions when it was not safe for them to do so. This meant lessons had not been learned by the service and the risk effectively mitigated.

This failure to ensure systems protected people who used the service from abuse was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

These incidents had not been reported to CQC or to the local authority safeguarding team. This meant these incidents were not able to be monitored sufficiently in order to protect this person, and others, in the future. The person concerned had come to harm after leaving the service for the third time and died.

This failure to notify was a breach of regulation 18 (Notification of other incidents) Care Quality Commission (Registration) Regulations 2009.

●Staff received training in safeguarding people from abuse and demonstrated that they knew how to spot the signs which might indicate that a person was being abused or at risk of abuse. Staff knew how to report any abuse both within the organisation and externally. However, training was not always implemented into practice.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks were assessed and documented in care plans. These risks related to a variety of issues including falls, choking, eating and drinking enough and the risk of developing a pressure ulcer. We found some of these risks had not been fully assessed and mitigated.
● Care plans failed to fully document the increased risks blood thinning medicines posed to people if they had a fall or injury. We noted that some risk assessments for this were in place but some were incomplete. One person's assessment was almost entirely blank and gave no guidance to staff.
● Food and fluid charts were in place for some people. These were designed to monitor people's eating and drinking to ensure prompt action could be taken if they were not eating or drinking enough. We found these were not always filled out correctly and where people had failed to eat or drink enough, action was not always documented. We could not be assured all the people who used the service were fully protected from the risk of not eating or drinking enough.
● We identified some risks posed by the environment. A communal café area contained a hot drinks machine, above which was a notice warning of the presence of boiling water. Staff confirmed that no risk assessment had taken place with regard to people living with dementia, or other health conditions which might cause them to become confused. There was no action taken to mitigate this risk of people scalding themselves and some staff were not clear about how many people who used the service had a diagnosis of dementia.
● We also noted small sweets and biscuits in communal snack stations. There had been no risk assessment of these relating to people living with dementia who were independently mobile or who might have swallowing difficulties. There was a risk of people accessing these snacks when it was not safe for them to do so, due to a particular dietary requirement for example.
● Small cabinets were placed around the service and were fully accessible. These contained latex gloves, plastic aprons and small bottles of alcohol gel. No risk assessment had been undertaken relating to any potential choking or ingestion risk these posed to people.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the most recent incident where a person had left the service when it was not safe for them to do so, additional alarms and locks had been fitted to external doors. On the day of our inspection this work was underway and some external doors were still awaiting these additional alarms. The service has confirmed that these works are now all complete.
● Routine maintenance of the service was well managed with regular safety checks.

Using medicines safely
●Medicines, including controlled drugs, on both units were well mostly managed and well documented. The particular risks relating to blood thinning medicines needed further review to ensure all staff were clear about these.
● Staff received training in administering medicines and had their competency to do this checked.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. There was no specified area for staff to put PPE on and take it off. This increased the risk of infection spreading during a pandemic. We also identified that further thought could have been given to how to manage the risk of people living with dementia who might walk around the service even when this was known to increase the risk.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
●The service appeared clean and there were no odours. A cleaning schedule was in place for communal areas and for each person's individual room.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

● No signs were in place to alert people to sloping floors in some areas of the service. These slopes presented a trip hazard.

● The secure courtyard could be accessed from several parts of the service and some people told us they liked to sit out there. We observed that the courtyard was in a poor state of repair with broken paving slabs, smashed flower pots, uneven areas of paving, a lack of handrails and a broken table. All of these posed a risk to people using the courtyard. We fed back to the provider and they took immediate action to remove dangerous items and close off access to the courtyard until further permanent improvements could be made.

● Staff told us that the security of the service had been a concern to them for several months. They were aware that it was possible for people to leave the service as external doors were not alarmed and were sometimes propped open. The local authority carried out a quality monitoring visit in January 2020 and also identified this as an issue. Despite this no robust remedial action had been taken to ensure the security of the service so that people subject to a deprivation of liberty safeguard could not leave the service and put themselves at risk.

This failure to ensure the premises was secure and properly maintained was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Following the incident prior to our inspection where a person had left the service and come to harm, the provider had undertaken a full review of all external doors and we noted all doors were in the process of being alarmed and a secure perimeter fence was being installed.

●There was signage in place to help people navigate their way around the service and new signs were being put up during our inspection.

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

● People's needs were not always fully assessed, particularly those in receipt of short-term respite care. We asked staff on the residential unit whether everyone who comes to stay at the service arrives with a pre-admission assessment. One staff member told us, "Sometimes not and we have to ask the family." Another staff member commented, "We get a one page thing and we have to work it out." A third told us, "Sometimes we find out in the morning that a person is coming in the afternoon and there's no information about allergies etc."

● We reviewed one person's care plan who had moved in four weeks previously for respite care. Information

recorded on the medication administration record relating to additional risks posed to them from blood thinning medicines was incomplete. There was no information about this in their full care plan. We asked staff where this information would be, and staff told us that this person did not yet have a full care plan. A second person's pre-admission assessment was incomplete, and their care plan contained little detail about their life history and preferences related to their care.
● Care plans documented people's preferences, but some people told us that these expressed preferences were not respected. One person said, "My morning routine is to shower then cream myself…. Since being here I have not been offered a shower and I miss this."

Some people's needs were not fully assessed before a service was provided to them and some people did not receive care which reflected their expressed preferences. This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A new care planning system was being implemented at the service. This had been designed to ensure that people's needs would be more clearly and promptly identified to staff, especially agency staff, so that people would receive the care and treatment they needed. This had already been trialled successfully at one of the provider's other services.

Staff support: induction, training, skills and experience
● Staff told us they felt confident in their roles. However, we did find some staff were unclear about people's needs. For example three staff on the residential unit , including senior staff, were not able to tell us who was on blood thinning medicines and what additional risk this posed, who had a diagnosis of dementia or who had a deprivation of liberty safeguard in place. We judged that staff would benefit from further training relating to these issues.
● There was a high number of agency staff on the rota. Four permanent staff on the residential unit told us that some agency staff did not have the required training and skills needed and were therefore of limited assistance to them. They told us they had shared their concerns with the registered manager as this lack of skills increased the pressures on permanent staff.

This lack of key skills for some staff was a further breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During our inspection visit the managing director confirmed that they had sanctioned the use of different staffing agencies to ensure that staff supplied had the right skills and experience.
● Staff received a good induction and had received training which included moving and handling, safeguarding and infection control. Nurses were supported to update and increase their skills. Senior staff on the residential unit had been supported by the nursing staff to increase their skills, such as learning how to do basic dressings.
● Staff received supervision from their line manager. All staff we spoke with told us they felt supported, although staff on the residential unit commented that support from the registered manager could be better. Staff on the nursing unit felt very well supported by the clinical lead.

Supporting people to eat and drink enough to maintain a balanced diet
● People's weights were regularly reviewed. Where people were identified as having lost too much weight, they were promptly referred to the dietician or to the speech and language therapist if there were concerns about a person's ability to swallow their food safely. However, oversight of people's food and fluid intake on the residential unit was poor.
● Daily fluid targets for people on a fluid chart were not clearly recorded and one staff member told us they

were confused about how much people should try and drink in a 24 hour period. This meant there was a risk that people did not have enough to eat or drink as staff would not be promptly alerted so they could take action.

● The new care planning system includes a process for identifying such shortfalls and the provider explained that they would increase monitoring in the intervening period until the new system is in place. Management of people's food and fluids on the nursing unit was very good.

● People told us that the food was good, and we observed a very positive lunchtime experience. Where people needed support to eat their meals staff provided this at the person's own pace and were observed to be patient and kind. Adapted cutlery and crockery was provided to help people eat independently.

●Kitchen staff were very clear about people's dietary needs and had received appropriate training. Kitchens were well organised and there were plentiful supplies of fresh fruit and vegetables. People who used the service enjoyed the weekly breakfast clubs.

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

● There was a record of healthcare appointments in people's care plans. People received support from healthcare professionals as and when needed, such as GPs, psychiatrists, speech and language therapists, dieticians and occupational therapists.

● Relevant health information was recorded in care records to guide staff.

● People told us staff supported them to live healthier lives. One person commented, "They know me here and want to keep my independence…they have helped me put on weight."

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.

● We found that staff, including the registered manager were not clear about which people who used the service had a DoLS in place. This meant there was a risk staff would not be aware of what restrictions needed to be placed on a person to keep them safe.

● There was no system in place to monitor people who had been granted a DoLS. These are issued for a limited time only and expire if they are not reapplied for. We found that one person's DoLS had expired and no action had been taken to reapply even though they remained at high risk should they leave the service. There was also a risk that people could have their liberty unlawfully restricted as their DoLS had expired and no review of their capacity had taken place. This impacted on people's human rights.

● Where people who used the service had been judged not to have capacity to make their own decisions a best interests decision needed to be made according to a structured process set out in the MCA. We noted that in some consent to COVID-19 vaccination records this was not followed and the registered manager had given consent and signed paperwork as a record. The registered manager told us that healthcare colleagues administering the vaccine had required them to sign and so they had done so in order for people to access

the vaccine. They acknowledged this was not the correct procedure. We have shared this information with our primary medical services colleagues who may choose to follow this up with the healthcare professionals concerned.

● We noted in one person's care plan that they had been judged to have full capacity to make their own decisions. We also noted that they had a history psychotic episodes and delusional ideas which would suggest that their ability to give informed consent might fluctuate. This had not been considered and there was no reference to fluctuating capacity in their care plan.

● Another person's consent to care had been signed by their relative even though they did not have legal authority to do this and no best interests meeting was documented. A third person had been judged to have capacity to make their own decisions but their Do Not Attempt Resuscitation order had been signed by hospital and care home staff only. There was no record of any input from them or their family member, who had lasting power of attorney.

The failure to ensure that care and treatment was provided with people's consent and in a way that did not unlawfully deprive them of their liberty was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed staff routinely asking for people's consent to provide care and treatment as they carried out their roles. Staff were seen to make sure people were comfortable and happy to have their care needs met on each occasion care was offered.

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 good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Several people who used the service wished to place on record how highly they regarded the staff but how busy they felt they were. People had the impression that staff were too busy to stop and chat, although when they did we observed friendly and warm interactions. One person typically commented, "[The staff] don't usually come to see me or talk to me unless assisting me with my personal care."
- People's preferences about who delivered their care was not always respected. One person commented that they preferred female carers and this was what was recorded in their care plan. They told us, "I get embarrassed. I need support with my personal care and prefer females, but I have no choice in the matter."
- We spoke with one person who told us that staff were really committed to enabling them to increase their skills and independence so that they could return to independent living following a period of rehabilitation. They praised the kindness and patience of the staff.
- We observed staff treating people with patience, kindness and respect and having a joke with them. One person told us, "The staff are good. They know me and they understand me."
- Care plans contained guidance for staff on how to try and maintain people's dignity, particularly when providing personal care.

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

- People were supported to express their views about their care and treatment. Staff were expected to review people's care plans with them each month and give them an opportunity to comment and raise issues. Staffing levels meant that sometimes this process was brief.
- Formal care review meetings, which may include relatives, had not been able to be held during the pandemic. Some people were unclear when their last meeting had taken place.
- Holistic reviews of people's care on the nursing unit had been suspended during the pandemic but were due to restart. These reviews looked at people's health and social care needs together.

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

● Systems did not ensure that care plans clearly identified all the needs people had and did not outline actions staff needed to take to meet them. Staff were not always clear about people's needs related to their physical and mental health conditions.

Arrangements were not in place to ensure that people received care that was person-centred. This was a further breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Each person had a 'This Is Me' document which contained key details about their care and support needs and preferences. A brief overview of people's care needs was also placed in their room and new staff told us they consulted this, as access to care plans was not always possible on a busy shift.

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 received information in a format they could understand. Signage helped people navigate their way around the building, although sloping areas were not clearly identified. Care plans contained guidance about how to communicate successfully with people.

● However, the provider had not fully considered the communication needs of people living with a degree of hearing loss during a period where all staff were wearing masks to cover their mouth due to COVID-19 infection control measures. One person's care plan indicated that they may be able to lip read and staff confirmed other people had hearing loss.

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

● There was a new activities co-ordinator recently in post and we observed some group activities taking place. People clearly enjoyed these.

● Three of the people we spoke with told us they were aware of the activities offered but chose not to take part as they weren't suitable for them. We did not observe any activities for the people who were nursed, or who chose to spend time in their rooms

● However, the provider had commissioned a survey to be given to each person who used the service to get

an overview of exactly what activities and social opportunities people wanted.
● The provider was following current government guidelines about enabling people to visit their relatives at the service. A visiting pod had been set up to do this safely and we also observed people chatting to their relatives in the garden.

Improving care quality in response to complaints or concerns
● There was a complaints policy and procedure in place. We reviewed nine complaints. Written and verbal complaints were recorded and well managed in line with the provider's policy.

End of life care and support
●People's end of life wishes for their care were clearly recorded in their care plan.
● As people approached the end of their life staff ensured anticipatory medicines were in place which were designed to ensure any pain or distress was controlled.
● Relatives were kept informed and staff were able to tell us how they had sought to continue to do this during the pandemic.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider failed to ensure they had effective systems to assess, monitor and improve the quality and safety of the care provided. This was a breach of regulation 17 (Good governance.) An action plan was drawn up outlining how the provider would bring about the improvements needed. At this inspection we found that enough improvement had not been made and the provider remains in breach of this regulation.

- Systems designed to asses, monitor and mitigate risk were not fit for purpose.
- Systems to monitor people's health and care needs were not robust.

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

- There was a registered manager in place, but they did not always demonstrate a thorough understanding of regulatory requirements. We found that some incidents had not been notified to CQC or to the local authority safeguarding team, as is required.
- We found that the nursing unit was functioning more effectively than the residential unit. The clinical lead on the nursing unit, who was also the deputy manager, provided strong and clear leadership and systems worked well. Staff on the residential unit were less clear about their roles and oversight of this unit, at all levels, was poor.
- Systems designed to monitor the service's performance were not effective. Nursing audits were of good quality and we saw there was good oversight of wound management and of people's pressure areas, and their eating and drinking. However, audits on the residential unit did not identify the issues we found relating to risk and to eating and drinking. This placed people at risk of harm.
- Environmental audits did not identify and mitigate safety concerns relating to the security of the building and to poor maintenance which made parts of the service unsafe.
- As stated earlier in this report, there was no system in place to monitor when DoLS expired and needed to be reapplied for. Medicines audits had not identified the lack of risk assessments relating to blood thinning medicines and recent medicines audits had not taken place.
- There was no effective overarching audit carried out at a regional level and the provider had not identified any of the issues which we found on our inspection. The managing director confirmed to us that audits designed to monitor the overall performance of the service were 'hit and miss' and were not fit for purpose.

Systems designed to monitor the safety and quality of the service and take action to mitigate risk, were not robust. The service was a repeated breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, at the previous inspection. Sufficient improvement had not

been made since that inspection and the service remains in breach of this regulation.

● Since our inspection a new system of audits has been introduced and a robust service development plan has been put in place to keep all areas under regular review. The provider is keeping CQC fully informed of the progress they are making to address the serious concerns we identified.

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 been open and honest when things had gone wrong, including the most recent incident where a person had left the service and come to harm. Records showed relatives had been contacted when an incident occurred concerning their family member.

● During our inspection process the provider was very open about the failures of the service and accepted our feedback, confirming they were already addressing the issues through changes to systems and staffing deployment.

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

● Although the registered manager told us that the service was 'one service', with staff from both the nursing and residential sides supporting each other and working in the same way, we found a divided culture. The nursing unit was mostly working well, with strong leadership from the clinical lead. The residential unit had multiple concerns and staff told us they were stretched and felt unsupported.

●Staff received supervision from their line manager, and staff on the residential unit spoke highly about the support from their head of care but did not feel supported and informed by more senior management. Staff told us they had raised concerns about the quality of some agency staff but nothing had changed. Given that the service relied heavily on additional agency staff there was an impact on the quality of people's care.

Working in partnership with others.

● Although part of a small group of care homes, there was no partnership working between the services which meant staff in some key roles did not benefit from any peer support.

● The service worked well in partnership with other agencies and healthcare professionals

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

● There were systems in place to engage people who used the service and seek out their opinions, but these had not always been well used. However, the managing director showed us some new questionnaires which were being sent out to people to help gauge opinions on aspects of the service including meals and activities. The provider had also begun redeveloping the courtyard area by the second day of our inspection. People who used the service were being asked for their opinions on how they wished to use this space in the future and what they wanted to be included.

● Residents' and relatives' meetings had been suspended due to infection concerns relating to Covid-19. However, people who used the service were not able to tell us what alternative methods of obtaining their feedback had been put in place during this time.

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The provider failed to notify us of relevant incidents. Regulation (2) (a) (iii) and (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider failed to ensure people had a comprehensive assessment of their needs and preferences. Regulation 9 (3) (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider failed to ensure care and treatment was provided with the consent of relevant people. Regulation 11 (1) and (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider failed to ensure risks to people's health and safety were assessed and mitigated. Regulation 12 (1) (2) (a) and (b).

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to operate an effective system to protect people from abuse or improper treatment. Regulation (10 and (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure premises were secure and properly maintained. regulation 15 (1) (b) and (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were enough competent, skilled and experienced staff to meet people's needs. Regulation 18 (1).