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Alexandra Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Alexandra Lodge is a residential care home providing personal care to up to 19 people. People are supported in 1 adapted building. The service supports older people, some of whom are living with dementia and mobility needs. On the first day of our inspection, there were 10 people using the service.

People's experience of using this service and what we found
The home was not safe. Environmental risks were not well managed. For example, we found the provider had not been carrying out fire safety checks when they should, to ensure fire related risks were managed. People were at increased risk of developing pressure ulcers. The provider did not ensure risks relating to people who could experience falls were well managed. Lessons had not always been learnt following incidents and accidents. People were not always protected from the risk of abuse and improper treatment. Staff were not recruited safely. Protocols for medicines used as required were not always in place. However, medicines were stored safely.

Records showed staff had not received up-to-date training. Staff did not receive regular supervisions from the provider. People's care plans were not always reflective of their current needs. People did not have access to regularly planned activities. The provider had not always made referrals to external health professionals where people required additional support relating to falls and times when they could experience emotional distress. However, people's nutrition and hydration needs were met.

Where people lacked the mental capacity to make specific decisions, best interests decisions were not documented. This meant; people were not supported to have maximum choice and control of their lives, and staff did not have the information they needed to support them in the least restrictive way possible and in their best interests; there were no policies and systems in the service to support this practice.

The home was not well led. The provider had no established policies in place for recruitment, accidents and incidents and falls. This meant there were no set standards and clear expectations for ensuring quality and safety in these areas. Environmental, care plan and medicines audits carried out by the provider were not always completed accurately, which increased safety risks to people. The provider and a relative told us opportunities for social activities, such as parties, needed to be improved. However, relatives told us they were kept up to date.

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

Rating at last inspection
The last rating for this service was good (published 22 June 2018).

Why we inspected
This inspection was prompted by a review of the information we held about this service. As a result, we

undertook a focused inspection to review the key questions of safe, effective and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

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.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection. We found evidence the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to safety, safeguarding people from the risk of abuse, staffing, person centred care, ensuring people's consent to the care they receive and good governance 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 an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Alexandra Lodge Care Home

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried by 2 inspectors. A regulatory officer from CQC's support services also spoke to relatives on the telephone about their experience of the care provided.

Service and service type
Alexandra Lodge 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. Alexandra Lodge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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 and professionals who work with the service. 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
We spoke with 2 people who used the service. We spoke with 2 relatives about their experience of the care provided. We spoke with 7 staff including, a domestic staff member, a cook, care assistants, senior care assistants and the provider. We reviewed 4 people's care records. We looked at 4 staff files in relation to recruitment practices. We reviewed various records relating to the management of the service including training records, safety checks, incidents, and accidents.

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.

Assessing risk, safety monitoring and management

● Risks to people's health and safety were not well managed. Poor home maintenance meant an increased risk of injury to people. For example, the carpet at the top of a staircase where a stair lift was located was loose. In addition, the loft space and an unsecured unused bedroom were highly cluttered. This increased trip hazards to people, and the accumulation of combustible materials such as paper and flammable liquid items increased fire risks.

● Personal emergency evacuation plans (PEEPs) had not been reviewed to ensure they were current. This meant in the case of an emergency such as a fire, rescue teams and staff would not have up-to-date information on how people needed to be evacuated. Furthermore, 1 person had been cared for in bed for the past 3 years, and their PEEPS stated staff should support them to evacuate in a wheelchair. Given the time they have been cared for in bed, it would be unlikely they could sit safely in a wheelchair due to loss of muscle tone. This meant increased safety risks to people in the event of an evacuation.

● Fire risks were not always well managed. The provider had not followed their schedules for checking fire safety equipment. For example, the weekly fire alarm test had not been done since January 2023. In addition, not all fire doors operated as they should; 3 doors were catching on the carpet in people's bedrooms, meaning they did not close automatically from being fully opened, and 2 doors did not close automatically into door frames. This increased fire safety related risks to people.

● Risks relating to hot surfaces were not always well managed. Two radiators in the lounge did not have radiator covers fitted, and we found a radiator cover in a person's bedroom was no longer secured to the wall. The provider had not carried out risk assessments for 2 people using portable radiators. Accidents had occurred where people had fallen, and some people's care needs included their reduced mobility. This meant they were at greater risk of falls and burns from hot surfaces.

● Freestanding furniture was not always secured to manage falls related risks. We found 2 cabinets in the lounge and a chest of drawers in a person's bedroom were not secured to the walls. This increased risks to people who could seek to hold onto furniture to prevent falling or pull themselves back up.

● Window restrictors were not always fitted to comply with Health & Safety Executive (HSE) Guidance. Restrictors fitted to people's bedroom windows on the first floor were not tamperproof or robust. A first-floor hallway and bedroom window did not have any restrictors fitted. This increased the risk to people who could fall out of windows.

● The provider did not have established relationships with external contractors to ensure any required building repairs could be carried out promptly. The provider told us they were aware of some of the environmental issues but had been let down by contractors who did not turn up. This meant in the absence of a maintenance person, there were no systems to ensure environmental safety risks to people could always be promptly mitigated when repairs were needed.

● Care plans were not in place to guide staff about how they needed to support someone to change position

to deliver care, such as helping them to get dressed. Although the provider and staff we spoke with told us 2 staff members helped this person do this as they could not move, there was no guidance about what equipment staff should use. This increased health and injury related risks to people.

Learning lessons when things go wrong

● There were increased risks of people developing pressure ulcers to areas of their body. Records from April 2023 showed a person was not moved (repositioned) in line with their care plan for 29 days. People are repositioned when they cannot do this for themselves to prevent pressure ulcers. We presented this concern to the provider on the first inspection day. However, when we returned 6 days later, we found this still had not improved. The provider had not responded promptly to our safety concerns, which further exposed the person to the increased risk of harm.

● The provider had not carried out monthly falls audits since December 2022. Furthermore, we found a falls audit completed in November 2022, did not include all falls a person had experienced. Falls audits help identify themes and trends to mitigate risks to people who could experience falls and can prompt actions such as involving GPs to review people's health for any contributing underlying conditions. Inconsistent and inaccurate falls monitoring meant people were at a higher risk of falls and potential injuries.

● Antecedent Behavioural Consequence monitoring charts (ABCs) were not always completed correctly by staff. ABC charts are a tool used to identify and analyse reasons for people experiencing emotional distress and the effectiveness of staff intervention, such as providing reassurance. Staff had not always correctly recorded how they supported people with their emotional distress. This meant lessons could not always be learnt to inform care plans to guide staff to consistently support people with the emotional distress they could experience.

Using medicines safely

● There were no risk assessments in place to guide staff on when to seek medical advice for a person at greater risk from falls because they were taking blood thinning medicines. This meant there were increased health related risks to this person due to a lack of guidance for staff to follow if this person experienced a fall. Blood thinning medicines (anticoagulants) increase the risk of internal bleeding when people who take these medicines are injured.

● Protocols for medicines used on an as required basis (PRN) were not always in place. PRN protocols give guidance to staff about when a medicine should be given and any specific safety instructions relating to them. This increased the risk of staff not knowing why and when people needed their PRN medicines. The provider responded to this immediately during the first day of our inspection and started handwriting missing protocols.

● There was not evidence that all staff who supported people with medicines had been trained to do so. This increased the risk of staff not having the skills and knowledge to ensure people received their medicines safely.

Systems were not in place to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This exposed people to the risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored safely and records showed people were receiving daily prescribed (none PRN) medicines safely. There were arrangements in place to ensure medicines were stored at correct temperatures. Medicines were secured and the staff checked stocks of controlled drugs.

Systems and processes to safeguard people from the risk of abuse

● The provider did not always challenge poor practice concerns. We found the provider had signed off daily

repositioning charts showing a person had not been repositioned when needed. We asked the provider why they had not addressed this, given they were aware of and signed these documents. They told us they had raised this with staff, but staff did not feel comfortable disturbing the person when they were asleep. As a result, action had not been taken to ensure the person's needs were not neglected. This meant the provider had not protected the person from neglect and improper treatment, and systems were not established and operated effectively to investigate these concerns despite being aware of them.

● During the inspection, we found concerns indicating people's health needs were neglected by the provider and staff. In addition to a person not being supported to change position in line with their care plans, we found another person had not been referred to health professionals after experiencing increased falls. As a result, we referred these concerns to the local authority safeguarding team.

The provider had significantly disregarded people's need for care and treatment. The provider did not respond appropriately when they became aware of evidence of abuse or improper treatment. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The emergency evacuation plan created in 2018, was 5 years out of date and had not been updated to reflect people's current needs. For example, a person using the service was cared for in bed and would need 2 staff members to help them evacuate. However, there were only 2 members of staff scheduled at night. This meant there might not be enough staff to support them simultaneously as other people needed staff to help them evacuate. In addition, some people could walk with purpose and, at times, be disorientated due to living with dementia. This meant in the case of an emergency; there was not always enough staff to ensure the safe evacuation of people.

● The provider did not operate a system to determine the number of staff needed to operate the home safely. This meant the provider had not considered the staffing levels and skills mix needed to meet people's needs.

● A staff member told us in response to us asking if they always have enough time to meet people's needs without rushing, "Not Always no; when it's only one carer on. Quite often, the senior carer is on their own." During the inspection, the provider told us there should be a minimum of 2 staff on duty at all times. However, staff schedules showed 4 occasions where only 1 carer was scheduled in the morning. In addition, after the inspection, the local authority shared a staff schedule with us showing a further occasion where there had only been 1 carer scheduled. This meant the provider had not always ensured there were enough staff to meet people's needs.

The provider had not always ensured there were sufficient numbers of staff employed and deployed throughout the service. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not operate any recruitment policies and procedures. This meant there were no set standards concerning pre-employment checks to ensure staff were suitable and recruited safely.

● There was no evidence of staff being interviewed before employment. We looked at 4 staff files in relation to recruitment and found no interview notes. This meant there was no evidence the provider had consistently assessed staff's character and competence before offering employment.

● There was a lack of robust processes to ensure previous employment references obtained were of a consistent standard. For example, we found the provider had accepted references from sources different to what a staff member had provided on their application form without a documented rationale for this. In addition, the provider had written their own undated reference about another staff member, based on their assessment of their character when they worked at the home 14 years prior. This meant references were not

used to help the provider make safer recruitment decisions.
● The provider had not ensured they met their contractual obligations with the local authority for regular DBS checks for existing staff. DBS checks provide information, including details about convictions and cautions held on the Police National Computer. We found a staff member had not had a DBS check carried out since 2005, and records showed 11 other staff had not had a DBS check within the past 3 years. This meant there was an increased risk staff were not suitable for their roles.

The provider had failed to implement and operate effective systems to ensure safe staff recruitment. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● There was a mixed response regarding visiting people at Alexandra Lodge. A relative had complained as they were told they could not visit after 6 pm. The provider and a staff member told us they felt this was too late as some people would be having supper and going to bed. However, 2 other relatives told us they felt free to visit when they wished. People should not experience any unnecessary visiting restrictions. We will continue to monitor and act on information we receive about visiting.

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 supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Inadequate

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

- Staff had not always completed and refreshed all required training. The provider did not operate any policies or systems which identified what training they expected staff to complete. We found the provider was also not meeting the local authorities' contractual requirements for training they expected the provider to ensure their staff completed. For example, not all staff had completed yearly training such as first aid, fire safety and safeguarding. In addition, there was no evidence staff had completed other required training such as person-centred care, dignity, medicines management or end of life care. This meant the provider had not considered and ensured staff had the skills and competence to care for people safely.
- The provider could not provide evidence staff had completed the care certificate. CQC expect providers to be able to demonstrate staff have or are working towards the care certificate. The Care Certificate is an agreed set of 15 standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. This meant there was no evidence staff had demonstrated the ability to work in line with the minimum standards expected of their roles to safely provide care to people.
- The provider could not evidence staff received regular supervision, and records showed 7 staff out of 11 had not received a supervision this year. Furthermore, we found no evidence the provider had any systems to observe staff practice and their competence in providing care and support to people. This meant there was an increased risk staff were not being supported appropriately and consistently with supervisions by the provider to ensure their competence and good standards of care were maintained for people.

The provider did not always ensure staff had the training and skills they needed to effectively meet people's needs. There was no evidence staff had received consistent supervision. This was a breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's care plans did not always inform staff of people's current care needs. For example, a person's care plan was not updated by the provider to reflect they now required support with their continence needs. Another person's activity care plan stated they could participate in seated exercises, but this was no longer possible as they had been cared for in bed for a significant amount of time. This meant the provider had not always ensured care plans were appropriate to guide staff in meeting people's current needs.
- Daily logs of care provided to people did not detail how their hygiene needs were met. Although staff recorded people had 'personal care', what this meant was not defined. For example, if a person had been supported to have a bath, shower, or wash. This meant the provider could not monitor if people's hygiene preferences and needs were maintained.

● During our first day of inspection, we did not observe any activities taking place. Staff told us regularly planned activities took place before the pandemic, but none had been planned since then. Although, on the second day of our inspection, a music and bowling activity took place in the morning, the lack of proactive activity planning increased the risk of people's social wellbeing and preferred activity needs not being met.

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

● The provider told us they had provided everyone living at Alexandra Lodge with an electronic airflow mattress. Referring to these mattresses preventing pressure ulcers, they told us, "We might as well have them, so we don't have an issue." Furthermore, they told us although people did not appear to mind, relatives had commented on the noise this mattress could make. However, whilst airflow mattresses can help promote skin health, we found no evidence that people's preferences had been considered concerning this decision or any discussion with people.

● Due consideration had not been made regarding an unsafe and unsecured cluttered room; connected to another person's bedroom. The room was used to store PPE, furniture, equipment and flammable substances and was separated by a waist-height ledge in the person's bedroom. The provider told us the original purpose of these 2 rooms was for couples who did not want to share the same room directly but still wanted to be close to one another. This, in addition to safety risks, meant the provider had not considered using other bedrooms for storage to make this person's room as homely as possible.

● The provider had not considered the appropriateness of the positioning of two cabinets in the lounge. In addition to these cabinets not being secured, they were positioned on either side of a ramp from the lounge to the garden area. This meant the provider had not always considered people's mobility needs in the layout of the lounge and walkways to promote accessibility and minimise the risk off falls

● In response to our concerns about portable heaters, the provider removed these from people's bedrooms rather than complete risk assessments to confirm their safety. The provider informed us portable heaters were no longer to be used in people's bedrooms. This indicated this was service led, rather than a person led decision. This meant people may not have had the additional heat source they may have required and preferred.

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

● The provider did not always refer people to health professionals in line with local authority guidance. For example, records showed a person had experienced 6 falls since October 2022. However, the provider had not made a referral to Nottingham City's integrated care home teams. This meant information had not been shared so external health professionals could apply their expertise in mitigating risks to people.

The provider did not ensure people received person centred care which met their needs and preferences. Relevant professionals had not always been involved with reviewing people's care needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A recording chart had been developed to improve communication with professionals about the progress of a person's pressure ulcer. The provider and a senior staff member told us they had done this as they struggled to get community nurses to provide clear details about the progress of the person's pressure ulcer.

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.

● Although we found evidence the provider had carried out mental capacity assessments where there were doubts people could make their own decisions, the provider had not documented best interests decisions where their assessments identified people did not have the capacity to make specific decisions. This included specific decisions around consenting to personal care and taking medicines. This was not in line with the principles of the MCA and meant there was no guidance to ensure staff always supported people consistently in line with what was in their best interests.

The provider failed to ensure they acted in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had appropriately made referrals to the local authority where they identified people were being deprived of their liberty.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff, including kitchen staff, understood people's dietary needs. This was most relevant to 2 people who needed softer diets. This promoted people receiving foods which were safe for them to eat.
● We observed food people were offered looked of good quality. A relative told us, "The food is lovely. They cook everything on the premises".
● Records showed people were offered plenty to drink. We also observed drinks were offered and made available for people throughout the day.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Care plan audits had not been used effectively to ensure current information was always in place or up to date. Although the provider carried out monthly care plan audits, we found these had not always resulted in changes and updates to reflect people's current needs. Our findings indicated care plans had become a tick-box exercise rather than being used for their intended purpose to ensure people were receiving care and support in line with their assessed needs and personal preferences.
- Although medicines audits prompt the provider to check PRN protocols, the last medicines audit completed in March 2023 and 2 previous audits had not resulted in the provider identifying that not all PRN protocols were in place. This meant systems to check whether medicines were administered safely were not effective.
- Environmental safety checks were not accurately completed or in line with the provider's schedules. Although audits existed which should have identified environmental concerns we found, such as fire safety and window restrictors, these were not accurately or objectively completed to identify shortfalls. Not operating systems to check the environmental safety of the home meant an increased risk of safety concerns not being noted and delays in remedial action, which exposed people to the risk of harm.

Continuous learning and improving care

- The provider did not have adequate systems to monitor staff training needs and evidence the training staff had received. In addition, we asked to review the provider's training record, as, at times, they provided care to people, but they could not provide evidence of this. This increased the risk of staff not having the required skills and knowledge to meet people's needs. There was also the risk that the provider themselves did not have the required training to support people safely.
- There was an inconsistent approach to documenting accidents and incidents. As a result, we found there was not always evidence actions had been taken following these events to mitigate risks to people. In addition, the provider did not have policies in place for managing accidents, incidents and falls. This meant effective systems were not in place to ensure a consistent response to improve people's safety following accidents and incidents.
- Concerns investigated by the local authority safeguarding team indicated a person had developed pressure ulcers due to not being moved as frequently as they should have been. However, this did not result in the provider ensuring another person was moved in line with their care plans. This meant lessons had not been learnt to ensure monitoring of people's repositioning resulted in increased safety and management of health-related risks.

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

● Although we found no evidence of the provider not acting openly and transparently regarding 'notifiable safety incidents', the provider did not have any policies and procedures around meeting duty of candour requirements. This meant there were no established systems to identify and respond to notifiable safety incidents effectively.

Working in partnership with others

● The provider did not always make referrals to involve health professionals to help manage risks to people, such as when they experienced increased falls and emotional distress. This meant the provider did not operate effective systems to recognise when people needed to be referred to external professionals in line with established local authority procedures.

●The provider also failed to meet deadlines in submitting information about training to the local authority. This was partly due to the provider's inability to use a computer and relied on a part-time admin assistant to undertake all computer-based work and communication on their behalf. The provider told us they used to have a manager overseeing their service but had not found themselves to trust anyone in this role since their departure. This system was ineffective and meant external professionals could not always be involved promptly in managing risks and improving the quality of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider recognised improvements to the service were needed. They told us, "We need to pick up again and get the home we have always had back." However, we found no documented plans to inform improvements to the service people received or that the provider had independently identified actions and concerns that needed addressing.

● The provider did not have established systems to ensure staff received consistent supervisions and had no policies around this. There were no effective systems to track when staff last had a supervision and when their next one would be due. This increased the risk of staff not being continuously developed to promote people receiving a good quality service.

The provider had failed to implement and operate effective systems to ensure the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider recognised they could not support any new people to move to the service. They had recognised it had been difficult since the pandemic to recruit new staff and felt it was more important to promote continuity of staffing, so people were supported by staff who knew them well. A staff member told us, "Because we are a small home, we know our residents."

● The provider and a relative we spoke with gave us similar feedback about arranging more social events. The person's relative told us, "The home used to facilitate garden parties in the summer for families and residents, which were well attended. They also took residents out on day trips, for example, to Skegness. However, this stopped during COVID and have not been reinstated. It would be nice if they started this again."

● We found evidence the provider had kept relatives up to date with important information. Communication with relatives was documented on communication sheets and staff handovers. Relatives we spoke with told us they were kept up to date about any important changes.

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 did not ensure people received person centered care which met their needs and preferences. Relevant professionals had not always been involved with reviewing people's care needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure they acted in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 significantly disregarded people's need for care and treatment. The provider did not respond appropriately when they became aware of evidence of abuse or improper treatment. This was a breach of regulation 13 (1)(3)(4)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The provider had failed to implement and operate effective systems to ensure safe staff recruitment. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Systems and processes did not ensure people received safe care and treatment. The provider had failed to mitigate risks relating to people's medicines, health and safety. This exposed people to the risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement and operate effective systems to ensure the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration.