Rehability UK Residential Ltd

Trinity House Care Centre

Inspection report

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Date of inspection visit:
28 April 2022
29 April 2022
04 May 2022

Date of publication:
23 January 2023

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Trinity House Care Centre is a care home providing personal and nursing care for up to 35 people. At the time of our inspection there were 21 people living at the home.

People's experience of using this service and what we found
We were not assured the provider was keeping people safe. The provider had not always fully assessed the risks to people's health, safety and welfare. We were not assured incidents and accidents involving people were consistently reported, recorded and investigated. People's medicines were not always managed and administered safely. The provider had not fully protected people from the risk of abuse and improper treatment. The provider had failed to ensure there was a consistent and effective clinical oversight of the service.

People's needs and choices had not always been appropriately assessed before they moved into the home to ensure effective outcomes of their care. We were not assured people's nutrition and hydration needs were being met. People were not always supported by staff who had the skills and knowledge to meet their needs. We were not assured the provider always liaised effectively with other agencies. The physical environment had not been adapted to take into consideration the needs to people living with dementia.

The provider was not working in line with the principles of the Mental Capacity Act 2005. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People's care records did not always include information about their preferences, personal history or background. People were not always encouraged to be as independent as possible. People's care records did not demonstrate people and their relatives were involved in decisions about the care provided. We observed staff treating people with kindness and compassion.

People did not have person-centred care plans in place to help staff ensure they received personalised care. Staff did not have clear written guidance on how to meet people's individual needs and preferences. People were not supported to follow their interests or take part in meaningful activities. People's information and communication needs had not been explored with them, recorded or communicated to staff to promote effective communication. People's end of life preferences had not been explored. The provider had a robust complaints procedure in place.

The provider had failed to implement effective systems to assess, monitor and improve the service. We were not assured the provider or manager understood their regulatory requirements. Records relating to people's care were not always accurate, up-to-date or complete and some records were illegible. The provider had not actively sought the views of people, relatives, staff or visiting professionals. We were not assured the

provider was acting in line with their responsibilities of the duty of candour. Staff we spoke with felt supported by the manager.

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

Rating at last inspection
This service was registered with us on 02 April 2020 and this is the first inspection.
The last rating for the service under the previous provider was requires improvement, published on 18 November 2019.

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

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

Enforcement and Recommendations
We 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 monitor the service and will take further action if needed.

We have identified breaches in relation to person-centred care, need for consent, safe care and treatment, safeguarding service users, meeting people's nutritional and hydration needs, good governance and staffing at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Trinity House Care Centre

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by one inspector on 28 April 2022 and 29 April 2022. A further site visit was conducted 4 May 2022 with two inspectors in attendance.

Service and service type
Trinity House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Trinity House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was not a registered manager in post.

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

During the inspection we spoke with four people who lived in the home and five relatives of people who lived in the home. We also spoke with 12 members of staff including the manager, managing director, quality lead, nursing staff, care staff and a cook. We also spoke with one visiting health professional. We reviewed a range of records, this included seven people's care records and five people's medication records. We looked at three staff files in relation to recruitment and staff competencies. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- We were not assured the provider was keeping people safe through assessing and managing risks to their health and safety.
- We were not assured people were receiving consistent support from staff in relation to the prevention and management of pressure sores. At the time of the inspection, there were five people in the home with pressure sores. Clear risk assessments and care plans had not been developed in relation to the treatment of all five people's pressure sores or the prevention of further skin damage. This meant people were at increased risk of further skin breakdown. In addition, we were not assured staff had liaised effectively with the tissue viability nurse. Where advice had been sought from them, care plans had not been developed to reflect the advice given. Furthermore, the advice given by the tissue viability nurse was not always followed by staff.
- The provider had not always fully assessed the risks to people's health, safety and welfare or put clear plans in place for managing these. This lack of robust risk assessments and care plans meant people were at increased risk of harm. For example, no risk assessments had been completed for two people at risk of falls. Furthermore, there was no clear guidance for staff to follow advising them how to mitigate the risk of falls.
- Where people had long-term medical conditions, plans were not always in place for managing these. For example, one person had been diagnosed with a long-term physical health disorder. Staff had not been provided with information about this disorder and no care plan was in place to guide staff on how to help the person manage this. This increased the risk of people receiving unsafe or inconsistent care.
- We were not assured incidents and accidents involving people were consistently reported, recorded and investigated to promote learning and minimise the risk of reoccurrence. We saw entries in one person's care records indicated they had fallen on five occasions. When reviewing the provider's incident log, only one of these falls had been reported. A further person had bed rails in place which had caused an injury. No bed rails risk assessment had been developed either prior to or following this incident. Furthermore, the incident had not been reported, meaning the provider had not investigated the event or made changes to reduce the risk of future harm.
- Staff we spoke with were aware of the provider's incident reporting process; however, the provider had failed to ensure it was consistently followed.

We saw evidence of harm to people. Systems were either not in place or robust enough to demonstrate safety was effectively managed, this placed people at risk of further harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During the inspection, we raised our immediate concerns with the manager, the provider and the head of quality and compliance. The provider acknowledged the seriousness of the concerns and took immediate

action to keep people safe. Following the inspection, we shared our concerns with the provider. The provider responded with an action plan specifically addressing the concerns above and outlining the measures they had put in place to keep people safe.

Using medicines safely

● People's medicines were not always managed and administered safely which placed people at risk.

● One person's medicines were administered covertly. This means medicines are administered in a disguised format, for example, hidden in food or drink. There was no clear procedure in place for staff to follow when giving this person their medicines covertly. Furthermore, the provider had failed to act in line with the Mental Capacity Act 2005 when making the decision to administer the medicines covertly.

● The provider had not always provided staff with written guidance on when to offer people medicines which were to be administered on an 'as and when required' basis (PRN medicine). This meant there was an increased risk PRN medication might be used inappropriately.

● One person's medication administration record (MAR) indicated they were prescribed a PRN medicine. When we checked the stock of this medication, the medicine could not be located. No record could be found to indicate that the person no longer required the medicine. This meant people were at risk of not receiving their prescribed medicines when required.

● People's prescribed creams and ointments were not always recorded on their MAR charts. Where this medication had been recorded on a MAR chart, staff had not been provided with clear instructions on when, where and how to apply the cream. This meant people were at increased risk worsening health conditions.

● Not all medicines were stored correctly. We found the temperatures of the medicines fridge were not recorded daily. Temperatures that had been recorded were found to have exceeded the range medicines were required to be stored at over a two-day period. The provider had failed to act on this information. This meant people were at risk of receiving unsafe medicines.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety in the management and administration of medication. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

●The provider had not fully protected people from the risk of abuse and improper treatment.

● The provider had failed to liaise with external healthcare services to ensure people were protected. For example, where people developed pressure sores, we were not assured appropriate and timely advice had been sought to address people's worsening condition.

● During the inspection, we raised a safeguarding concern with the local authority for four people regarding the care they received. The provider had failed to identify or report these concerns, meaning their safeguarding processes were not sufficiently robust.

● The provider had no system in place for monitoring the progress or outcomes of applications for Deprivation of Liberty Safeguards (DoLS) authorisations. We found three people's DoLS authorisations had expired and not been reapplied for without a clear rationale. This meant some people who were unable to consent to their care may be being deprived of their liberty without authorisation from the local authority.

The provider had failed to ensure people were protected from abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and their relatives told us they felt safe in the home. One person living in the home told us, "I love It

here; it feels like home." Another person's relative told us, "[Relative] is happy there and feels safe."

Staffing and recruitment

● The provider had failed to ensure there was consistent and effective clinical oversight and leadership at the service.

● People living in the home were predominantly supported by agency nursing staff as the home had limited numbers of permanent nursing staff. As people did not all have care plans and risk assessments in place, agency staff lacked a clear understanding of people's risks, care needs and preferences. This placed people at risk of receiving inappropriate care.

● For example, we spoke to one agency nurse working in the home who was supporting a person with their medication. The nurse was using handwritten notes taken from a verbal handover to inform her of people's needs. When asked about one medicine the person was prescribed, they were unable to provide any information as this had not been handed over. Furthermore, they were not able to find any information within the person's medicines or care records.

The provider had failed to ensure there were sufficient numbers of suitably trained staff. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider told us they were reviewing staffing structures across the service. The provider also recruited a clinical lead nurse who began working at the home shortly after the inspection.

Preventing and controlling infection

● We were somewhat assured that the provider was using personal protective equipment (PPE) effectively and safely. During the inspection we saw several staff wearing facemasks incorrectly. This was immediately addressed with the members of staff and the manager was also informed.

● 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 accessing testing for people using the service and staff.

● 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.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● We were assured that the provider was facilitating visits into the care home in line with current government guidance.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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.

- The provider was not working in line with the principles of the MCA. They were unable to evidence that people's rights under the MCA were being protected. Assessment and care planning processes did not always consider people's capacity to consent to care and treatment.
- Where people lacked capacity to make particular decisions, the provider had not assessed their mental capacity or recorded best-interests decision-making in line with the MCA. For example, one person's mental capacity assessment had resulted in them being assessed as 'lacking capacity'. The assessment lacked sufficient detail to evidence the decision-making process leading to this conclusion and was not decision-specific. This meant we could not be assured the provider was protecting people's rights under the MCA when assessing care needs and making decisions about people's care.
- Where it had been established people lacked capacity to make a particular decision, best-interests decision-making had not always been sufficiently detailed. For example, one person had two best interest decisions in their care records. These decisions did not include enough information to guide staff on how to meet the person's needs in line with their capacity and consent.

The provider had not consistently acted in accordance with the requirements of the Mental Capacity Act 2005. This was a breach of Regulation 11 (Need for Consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and choices had not always been appropriately assessed before they moved into the home to ensure effective outcomes of their care. Pre-admission assessments were not sufficiently detailed and did not consider people's physical, mental and social needs.
● Once people moved into the home, their care needs and choices were not regularly reassessed. For example, one person had a learning disability. The impact of this condition had not been assessed and a care plan had not been devised to provide guidance for staff on how to effectively support the person.

Supporting people to eat and drink enough to maintain a balanced diet
● We were not assured people's nutrition and hydration needs were being met as food and drink did not always meet people's assessed needs.
● Where people had been referred to the speech and language therapy (SALT) team, the outcomes of SALT assessments had not been clearly communicated to staff. We found that SALT guidance had not been clearly recorded in the relevant people's care plans or risk assessments.
● One person's SALT assessment stated they required a fortified diet consisting of foods that were soft and bite sized, to prevent weight loss and reduce the risk of choking. We saw no evidence that this guidance was being followed by staff. One staff member told us there was no one living in the home with any dietary requirements.
● Food and drink records were not consistently maintained or effectively used to monitor people had received sufficient or appropriate nutrition and hydration to meet their assessed needs.

The failure to meet people's nutritional and hydration needs was a breach of Regulation 14 (Meeting nutritional and hydration needs) of The Health and Social Care Act 2008 (Regulated Activities) Regulations

Staff support: induction, training, skills and experience
● People were not always supported by staff who had the skills and knowledge to meet their needs.
● Although the provider had a system in place to monitor staff training needs, they had failed to ensure training was kept up to date. We saw significant gaps in staff training records including safeguarding, fire awareness and manual handling.
● Staff did not always receive regular supervision to monitor and reflect on their practice, provide guidance and support, and identify areas for development. The provider's supervision schedule indicated multiple staff had not received formal supervision in line with the provider's policy. One member of staff who had worked in the home for a number of years told us they had not had any form of formal supervision or support.
● The provider had failed to ensure they were following their own induction policy. We saw no evidence new staff had undergone a formal induction process to integrate them into their new roles.
● The provider's staff induction did not incorporate the requirements of the Care Certificate as detailed in their own policy. The Care Certificate is aimed at ensuring health and social care staff have the knowledge and skills they need to provide people with safe and compassionate care.

The provider had failed to ensure staff received appropriate support, training, supervision and appraisal. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● We were not assured the provider had always liaised effectively with other agencies, teams and professionals to ensure people's health needs were monitored and met. For example, one person's known

skin condition had significantly worsened. Daily records demonstrated a delay in the provider seeking advice from other health care professionals on this deterioration.

● Another person had lost a significant amount of weight over recent months living in the home. The provider had recorded the weight loss; however, they had failed to analyse this or seek timely advice from healthcare services and support. This meant people were at increased risk of harm from worsening health conditions.

● Some people's relatives told us they were not kept up to date about their loved one's care. This meant people had less support to understand and be involved in decision-making about their health. For example, one person had had an injury whilst at the home. The person's relative told us the home had not made them aware of the injury.

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

● The physical environment had not been adapted to take into consideration the needs to people living with dementia. For example, there was a lack of signage in place to support people to navigate around the home. This meant people could not easily orientate themselves within the home. In addition, there was a lack interactive or dementia-friendly resources within the home.

● At the time of the inspection the main lounge was closed due to being redecorated. We saw the TV in the only remaining communal space was broken. Furthermore, the provider had organised no meaningful programme of activities for people to engage in. This meant there was a potential for people to become bored when living in the home.

● The provider had failed to ensure people had access to an appropriate outdoor space. The home's garden was in a state of disrepair with multiple hazards to people's health and safety.

● We shared these concerns with the provider during the inspection who immediately took steps to address the issues raised.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- People's care records did not always include information about their preferences, personal history or background. Permanent staff we spoke with demonstrated a sound knowledge of people's preferences. However, when we spoke with agency staff, they lacked this knowledge. As people's preferences were not recorded in care records, this meant people were at risk of receiving care from staff who were not supported to get to know them well.
- We observed staff treating people with kindness and compassion in their day to day care and support.
- People and their relatives told us they felt supported and respected in the home. One person told us "I love it here; I hope I can stay forever." Another person's relative told us "The staff like him there; they have a good rapport with him."

Respecting and promoting people's privacy, dignity and independence

- People were not always encouraged to be as independent as possible. Care records did not clearly detail what they could and could not do for themselves or give staff specific guidance on how to support people to maintain their independence. For example, one person had recently moved into the home. The provider had failed to record information in the form of plans or assessments to guide staff on the person's independence and ability to care for themselves.
- People's information was treated confidentially in line with the Data Protection Act. Care records were paper-based, held within a locked cabinet and only accessible to those that required access.

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

- The provider could not provide us with evidence they had actively sought feedback from people living at the service, relatives or staff members. The manager told us they had not sent out any questionnaires or feedback forms. This was confirmed by people's relatives. This meant people, their relatives and staff had limited opportunities to express their views about the care provided and how this might be improved.
- The provider had made information available to people and their families about advocacy services that can provide independent support and advice.

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not have person-centred care plans in place to help staff ensure they received personalised care. We found the extended use of '7-day care plans' for multiple service users, which, as temporary care plans, were only intended to inform staff how to meet their basic needs at the commencement of their care. Where 7-day care plans were no longer in use for people, we found care plans lacked sufficient detail of people's health and social care needs to guide staff.
- Staff did not have clearly-written guidance on how to meet people's individual needs and preferences, including the support people needed to manage long-term health conditions.
- People and, where appropriate, their relatives were not encouraged to contribute towards care planning. Care records did not demonstrate people and their relatives had been involved in the planning of care. One person's relative told us they had not had any contact about their relative's care needs or preferences since their admission to the home.
- People were not supported to follow their interests or take part in meaningful activities. Although the provider had employed an activities coordinator, they were undertaking other support tasks. We saw there was no activity timetable in place for people. This was confirmed by the manager.
- People's relatives told us they were concerned about the lack of meaningful activities in the home. One person's relative told us, "If I had one negative, it would be the lack of things to do. They need to put more on for people."

People did not consistently receive person-centred care based on an assessment of their needs and preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During the inspection, we raised our concerns with the provider who created an action plan to improve people's care plans. During our final visit to the home, we observed activities taking place.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's information and communication needs had not been explored with them, recorded or

communicated to staff to promote effective communication.
● We found the provider had not provided service users with all necessary information about their care in a way they understood. For example, one person's assessment stated they required information in easy-read and large-print format to assist their understanding. We saw no evidence of information being provided in this way.
● Another person living in the home was registered blind. The impact of this sensory loss had not been assessed during admission and care plans had not been made available for staff to follow when communicating with the person.

End of life care and support
● The manager told us there was one person receiving end of life care in the home at the time of the inspection.
● We looked at this person's care records and found no clear plan in place regarding the person's end of life care and preferences.
● Furthermore, we saw no evidence that people's end of life care and preferences had been discussed with them, their relatives and friends. This included a lack of any recorded discussions around pain management and plans for funeral arrangements.

Improving care quality in response to complaints or concerns
● We saw the provider had a complaints policy which was kept under review and followed.
● People told us they had not had reason to raise a complaint with the provider. People told us they felt the manager was approachable and responsive should they need to raise anything with them.

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.

This is the first inspection for this newly registered service. This key question has been rated 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; Continuous learning and improving care

- The provider had failed to implement effective systems to assess, monitor and improve the service. As a result, the provider had not identified the concerns we found at this inspection, including those relating to unsafe management of medicines, incident reporting and investigating, and the lack of robust risk assessments and care planning processes.
- The provider had completed regular care plan audits which were found to be non-compliant with their own quality standards. The provider had failed to take timely action to address the identified concerns and improve the governance within the home. This meant people were at risk of receiving poor quality care.
- The provider had not established robust systems and processes to enable staff to record and report accidents or incidents, and to ensure these were thoroughly investigated. This is important when attempting to minimise the risk of reoccurrence and drive improvement in the service. We saw multiple examples of unreported incidents.
- We were not assured the provider or manager understood their regulatory requirements or kept themselves up to date with these, including the need to notify CQC of relevant changes, events and incidents affecting the service and the people using it. For example, the provider had failed to notify us when people developed serious pressure sores in the home.
- The provider had failed to identify records relating to people's care were not always accurate, up-to-date or complete. Furthermore, we found some records to be illegible. People's health appointments and visits were not always recorded fully or accurately. This meant that there was no clear record of when people were seen by health professionals or what the outcome of their appointments or visits were.

The provider's quality assurance systems and processes were not effective and had not enabled them to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider is required to have a registered manager for the service. There was no registered manager in post at the time of the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- We saw no evidence that meetings with people and their relatives were taking place, to involve them in

the service, provide them with key updates and give them an open forum to raise suggestions or concerns. The manager told us they had not held any meetings with people and their relatives since they had been in post.

● People's care records indicated staff and management had not always engaged with other health professionals to ensure people's care needs were monitored and met. Communication with external professionals had sometimes been delayed. Furthermore, we saw that the information was not always effectively communicated to staff or reflected in people's care plans.

● Staff we spoke with understood whistleblowing and were aware of the provider's related policy. Whistleblowing is the term used when staff report certain types of wrongdoing within an organisation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 the provider and manager told us they understood the duty of candour, we were not assured they were acting in line with their responsibilities including the need to be open and honest with people when care had not gone according to plan. We saw evidence that the provider had not informed the relevant people when something went wrong with people's care.

● The lack of effective quality assurance systems, processes and audits meant management and staff did not have a shared understanding of challenges, concerns and risks in relation to people's care.

● Staff members we spoke with told us they felt supported by the management team and felt able to raise concerns if needed. One member of staff told us "[Manager] is supportive. I can go to them with anything."

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Systems for ensuring people's care and treatment was appropriate, met their needs and reflected their preferences were not being used effectively. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

NoP to impose conditions

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 failure to provide care with the consent of the relevant person is a breach of Regulation 11 (Need for Consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations

The enforcement action we took:

Warning notice

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	We saw evidence of harm to people. Systems were either not in place or robust enough to demonstrate safety was effectively managed, this placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

NoP to impose conditions

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 had failed to ensure people were protected from abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

NoP to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The failure to meet people's nutritional and hydration needs is a breach of Regulation 14 (Meeting nutritional and hydration needs) of The Health and Social Care Act 2008 (Regulated Activities) Regulations

The enforcement action we took:

NoP to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems and processes were not effective and had not enabled them to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

NoP to impose conditions

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 had failed to ensure there were sufficient numbers of suitably trained staff. This placed people at risk of harm. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

NoP to impose conditions