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Linda Lodge

Inspection report

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

Summary of findings

Overall summary

About the service
Linda Lodge is a residential care home providing personal care to 16 people aged 65 and over at the time of the inspection. The service can support up to 26 people in one adapted building

People's experience of using this service and what we found
We were unable to speak with people who used the service during this inspection because 15 out of the 16 people had tested positive for COVID-19 and it was not safe for us to do so. We contacted people's relatives by telephone and their feedback about the service was mostly positive. However, we needed to consider that the service had not been able to allow relatives inside for almost a year. Relatives may not have had an up to date impression of what the service was like at the time of the inspection as we found standards had deteriorated significantly since our previous inspection in December 2018.

The service was not safe. We found widespread and serious shortfalls in the prevention and control of infection. Staff did not always use PPE effectively, practise safe social distancing or complete cleaning tasks in line with current guidance. Waste and laundry were not always handled safely. People who tested positive for COVID-19 were not supported to self-isolate effectively.

Systems to assess and manage risks relating to both the home environment and individual people were not effective. We had particular concerns about risks relating to pressure ulcers and fire safety. Medicines were not always managed safely. There were no effective systems in place to follow up and learn lessons from incidents or safeguard people from abuse and neglect.

There were not always enough staff to support people safely and there was not an appropriate system in place to calculate appropriate staffing levels according to people's needs. Recruitment systems were not robust enough to ensure all the necessary checks were completed on new staff as required by law.

The provider did not fully understand their responsibilities and statutory requirements in terms of leadership and governance. Managers did not undergo appropriate training to ensure their leadership skills and knowledge were up to date. The provider had not told us about things they are required by law to notify us of, such as deaths of people who used the service. However, we received positive feedback about the registered manager from staff and people's relatives.

Record keeping was poor and systems did not allow the provider to maintain adequate oversight of the safety and quality of the service. The provider did not carry out or had not maintained a number of important safety and quality checks. They had therefore not identified several of the serious issues we found during our inspection or were not aware these were their responsibility.

When things went wrong or problems were identified, the provider did not always follow these up appropriately and there was no evidence of action taken to improve things. There were emergency

contingency plans but these were ineffective and had failed to prevent a serious deterioration in several aspects of the quality and safety of the service when an outbreak of COVID-19 affected the home.

People's needs were assessed before they started using the service but these assessments did not capture enough detail to produce person-centred care or ensure the service was able to meet their needs on an ongoing basis. People's care and support did not always line up with current best practice and guidance. Staff did not always have up to date training and support to enable them to do this.

The provider did not always do enough to ensure people had enough to eat and drink from a choice of varied and nutritious food. Unplanned weight loss was not always followed up promptly. There was not sufficient evidence to assure us people consistently received the support they needed to manage long term health conditions, although people did have access to healthcare professionals when needed and the service worked well with healthcare providers when they identified the need to do so.

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 did not always take into account their individual preferences and needs. Care plans were task focused and the routine of the service was often based on staff convenience and time constraints rather than people's preferences. People's cultural and religious needs and communication needs were not always fully considered. End of life care did not consider all aspects of people's preferences for the support they wished to receive at this time and information about this was not always gathered in good time for staff to be sufficiently prepared to provide personalised end of life care.

Staff enabled people to maintain relationships and contact with their relatives and loved ones as much as possible during the restrictions imposed on the service by the COVID-19 pandemic. We received positive feedback from people's relatives about this.

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 15 January 2019).

Why we inspected
The inspection was prompted in part due to concerns received about infection control, staffing, risk of neglect including malnutrition and dehydration, and leadership. A decision was made for us to inspect and examine those 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.

We initially undertook a focused inspection to review the key questions of safe, effective and well-led only. We also planned a targeted approach to look at only part of the responsive key question but during the inspection we found there was a concern with planning personalised care so we widened the scope of the inspection to include the whole of the responsive key question.

We reviewed the information we held about the service. No areas of concern were identified in the caring key question. We therefore did not inspect it. Ratings from previous comprehensive inspections for that key question were used in calculating the overall rating at this inspection.

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.

We received information from the provider after the inspection about action they were taking to reduce risks. However, we were not satisfied that this was sufficient.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Linda Lodge 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 safe care and treatment, need for consent, person centred care, safeguarding service users from abuse and improper treatment, good governance, staffing, fit and proper persons employed and notification of deaths and other events at this inspection.

After this inspection we wrote to the provider to tell them we intended to take urgent enforcement action unless we received assurance that people were no longer at immediate risk of harm. Although we were not assured by the provider's response to this, we were satisfied that the support given to the provider by the local authority was sufficient to keep people safe until the action we planned to take was complete.

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 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 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.

Linda Lodge

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 two inspectors working on site and one inspector working remotely.

Service and service type
Linda Lodge 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 met with local authority commissioning and safeguarding teams and with representatives from the local clinical commissioning group (CCG) to discuss concerns about the service. We reviewed information we already held about the service, including reports from previous inspections and data we received about a COVID-19 outbreak at the service. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the registered manager, deputy manager and eight members of staff including two members of agency staff working at the service. We spoke with three relatives of people who used the service. We checked eight people's care records, three staff files and a range of other records including health and safety records such as cleaning checklists.

After the inspection
We met remotely with the registered manager and deputy manager to discuss the management of the service. We spoke with a healthcare professional who regularly visited the service. We continued to work alongside the local authority to share information about risks to people who used the service. We reviewed additional records we had asked the provider to send us.

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.

Preventing and controlling infection

● At the time of our inspection there was an outbreak of COVID-19 which had affected all but one of the 16 people using the service. We identified that the service's COVID-19 risk assessment did not cover risks specific to the service such as the difficulties posed by the building's layout, or individual risks to people who were more vulnerable to COVID-19 because of health condition or other factors. This meant they had not fully considered what they needed to do to keep people safe.

● We found the provider had not attempted to follow guidance to create separate zones within the building for people who had tested positive and negative for COVID-19. They did not take precautions such as deploying dedicated staff only to work with those who had tested positive, to reduce the risk of them carrying the virus to people who did not have it.

● The premises were not hygienic. Clinical waste bins were hand operated and not foot operated in line with guidance. Some were open or overfilled exposing people to potential sources of infection. Dirty laundry for people who tested positive for COVID-19 was not kept separate from other people's. Care staff had to complete all cleaning tasks in between caring for people. Staff told us they could not always manage this when things were busy. Cleaning checklists did not indicate the cleaning regimen was sufficiently robust in line with current guidance for managing COVID-19 risks. These practices all increased the risk of infection spreading between people.

● Although the home was complying with guidance to isolate people who tested positive for COVID-19 in their bedrooms, we saw some of those people sitting beside their open bedroom doors and in some cases coughing. This meant they were not properly isolated from other people, staff and anyone else who passed by their rooms. On several occasions we saw staff not meeting social distancing rules or had to remind them to step away from ourselves.

● We saw staff wearing masks incorrectly or touching masks excessively while wearing them, which can contribute to the spread of infection.

● Although the registered manager described precautions they would take for new admissions, there was no written admissions policy in place to cover the additional infection prevention and control measures required to reduce risks associated with COVID-19. We were therefore not assured that such precautions would always be taken.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Most visitors were not permitted in the home. There was a room for visitors to wash hands, change clothes and to put on and take off PPE. However, staff were also using this room to take breaks and eat meals, which increased the risk of infection passing to visitors. The home had a policy to check visitors' temperatures on arrival, but this was not consistently applied as we were asked to do this on the second day of our inspection but not on the first.

● We were assured that the provider was accessing testing for people using the service and staff. Records showed and staff confirmed this was happening regularly.

Assessing risk, safety monitoring and management

● There were not sufficient safeguards in place to manage fire risks. Personal emergency evacuation plans were not sufficiently detailed to ensure people's safety in the event of a fire. The provider did not carry out regular fire drills with evacuation to ensure their plan was practicable and people would be able to leave the building safely.

● The provider had not done enough to ensure they were managing other risks to do with the home environment. They did not carry out regular health and safety checks of items such as water temperatures and call bells. There was no risk assessment to make sure people were not at increased risk from Legionella, a harmful organism that can reproduce in water supplies if they are not maintained safely.

● People had individual risk assessments but these were not detailed enough to ensure risks to their health and safety were adequately managed. For example, one person's smoking risk assessment did not consider the risks around a health condition they had affecting their lungs or how staff could identify the signs of respiratory failure. Agency staff told us the risk assessments did not give them all the information they needed to care for people safely.

● There was no individual assessment of the risk of people developing pressure ulcers as the provider did not consider factors such as weight, activity levels or nutrition which can all affect this risk. The provider had not considered this risk may have been elevated at the time of our inspection as people were confined to bedrooms because of the COVID-19 outbreak and were spending more time sitting or lying down than usual.

Using medicines safely

● The systems to ensure people received their medicines safely and as prescribed were not adequate. While medicines people took regularly were appropriately handled and recorded, their medicines to be taken only as and when required (known as PRN) were not managed safely. We noticed one person had only one tablet left of a PRN medicine they were taking several times a day at the time of the inspection. Staff had not noticed the low stocks and suggested offering the person a different PRN medicine while they waited for more supplies, but this was not good practice as the other medicine was prescribed for a different reason and may not have been suitable.

● PRN medicines were not always recorded appropriately. A separate PRN recording sheet was in use alongside people's regular medicines records and both were used to record medicines but not consistently. In some cases this may have led to confusion over whether people had already received a dose which meant there was a risk of overdose.

● Medicines stock records were unreliable, meaning there was insufficient assurance people received their medicines as prescribed. For four out of five people whose medicines we looked at, the amount of PRN medicine in stock differed significantly from what records showed there should be. Staff were unable to account for these discrepancies.

Learning lessons when things go wrong

● The service did not have a reliable system for identifying trends and patterns in accidents and incidents. The registered manager told us they regularly read incident reports and gave an example of action they took when they noticed one person was falling frequently. We saw evidence they had responded appropriately in this case. However, this method meant there was a risk they would miss patterns that were not immediately obvious, such as more falls happening at particular times of the day.

● Incident records were not sufficiently detailed to enable the provider to monitor action they took in response. The records contained information about what happened, but not about what was done next to stop the incident happening again. This also meant in some cases there was no evidence the provider took

appropriate action in response to incidents where people were harmed.

The evidence above in relation to infection prevention and control, risk assessment and management, medicines management and learning from incidents meant that the service was in 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

● We heard several accounts from the local authority, healthcare providers and agency staff of the service failing to provide people with the care they needed. Examples included people showing signs of thirst and dehydration and having no access to drinks, and people found wearing heavily soiled incontinence pads with skin damage indicating their personal care needs had not been met properly for several days. Although the provider had since taken action such as supplying more cups so people always had drinks in their rooms, we were concerned staff had not identified or reported these issues as neglect.

● Systems to protect people from the risk of neglect were therefore not effective. Although the service had policies and procedures for identifying and reporting abuse and neglect, these had failed to ensure people's safety at the time of the inspection and staff did not have up to date safeguarding training to enable them put the policy into practice.

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.

Staffing and recruitment

● There were not enough staff at all times to care for people safely. We received concerns before the inspection that there were only two staff on duty to care for 20 residents. The local authority had arranged to provide additional agency staff as the provider did not have enough staff available to cover the service. We looked at rotas for the last four weeks which confirmed it was usual practice for no more than two staff to be on duty after 6pm to care for up to 20 people. This was especially concerning as people were confined to individual bedrooms because of the COVID-19 outbreak, meaning staff could not have sight of more than one person at a time. Because the majority of people were unwell, they also required more support than usual to ensure their condition was not deteriorating.

● At the time of our inspection there were no dedicated staff to carry out cooking and cleaning tasks, which staff had to do in addition to caring for people. Staff told us they often came on shift to find their colleagues had not had time to complete cleaning and laundry tasks, which put people at increased risk of being exposed to infection during the COVID-19 outbreak.

● The service did not have a suitable system to assess staffing needs. One person's relative told us there was a "minimal staff team" although they felt the service did very well to meet people's needs with few staff. There was no dependency tool or other measure in place to look at people's care needs and calculate how many staff were needed. When we asked how they decided how many staff were needed, the registered manager told us this depended on availability of staff. This indicated staffing levels were based on convenience for the service rather than the needs of people who used it.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The law requires social care providers to carry out certain checks on new staff before they start providing care to people. The provider had completed most of these checks. However, they did not have a robust system to ensure these were done and when we drew their attention to information that was missing from staff files, they were unaware it was not in place. There was no policy for updating criminal record checks at

any particular frequency. This is important because some staff had been working at the service for several years during which their circumstances may have changed.

This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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

- The provider regularly sent updates to staff about current guidance and best practice and the registered manager spoke with staff daily about this. However, they did not check staff understood this and were putting it into practice. The evidence we found showed people's care at the time of the inspection did not reflect current guidance and legislation.
- People's needs were assessed before they started using the service. These assessments were not thorough or detailed enough to produce care plans that were a full reflection of people's needs and choices. For example, assessments did not cover in full people's needs and preferences in terms of culture and religion, hobbies and interests, healthcare support needs or their personal care routines.

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

- The provider had not taken adequate steps to ensure people had enough to eat and drink. Care plans did not contain detail about what type of diet or how much people needed to eat and drink to meet their needs. Records showed at least three people had an unplanned loss of between 10 and 20 percent of their body weight over the last six months to a year. However, this was incorrectly recorded on malnutrition risk assessments and records did not show factors such as people's height that would indicate whether the weight loss was a cause for concern. In all but one case, there was no evidence of the provider taking action in response to the weight loss.
- Menus did not reflect a variety of nutritious food chosen to reflect people's needs and preferences. For example, two people preferred vegetarian food but the menu did not always offer vegetarian choices and when it did these were not always nutritionally balanced or varied, with the same dishes appearing on menus four or five times over a four week period.

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

- People did not always receive support to manage health conditions appropriately, meaning they were at increased risk of becoming unwell. For example, there was no information in care plans for people with diabetes about how to meet their dietary needs. Some care plans stated people should eat a "diabetic diet" but there were no details about what this meant and the care plans suggested snacks that were not in line with guidance about healthy diets for people with diabetes. The health professional we spoke with told us there was a risk some health issues were being missed partly because records were not always clear and complete.
- Although the provider made appropriate referrals to other agencies to support people to meet their

healthcare needs, they did not always do this in a timely way when needed. For example, the provider had referred one person to a dietician after a significant weight loss, but this was not done until they had lost 20% of their body weight over eight months.

The evidence above in relation to assessing people's needs in line with guidance, nutrition and hydration and supporting people to live healthier lives is a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was evidence the service worked alongside healthcare professionals when they were involved with people's care and people had regular access to healthcare professionals. Advice and guidance from professionals had been added to care plans in some cases and the registered manager told us they had a good working relationship with healthcare providers.

Staff support: induction, training, skills and experience
● Staff did not have all the training they needed to provide people with safe and appropriate care in line with current standards and guidance. Records showed staff had not received training in several key areas including safeguarding people from abuse, health and safety and, in all but two cases, basic first aid. Three members of staff had received only one training course in the last two years and another had none. Although staff felt they had the training they needed, some said this was a long time ago and they would benefit from refresher courses.
● There were no effective systems to make sure staff were competent, knowledgeable and properly supported. One member of staff had not had a medicines competency check despite having made errors administering medicines. Three out of 10 staff had received no supervision or appraisal in the last year and another four had only received one supervision or appraisal session in this time. Although the registered manager told us they met with staff daily during handover, this did not give staff and the registered manager the opportunity to discuss and monitor individual training and support needs.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

● The provider did not always adhere to the MCA to either enable people to make decisions about their care or follow the appropriate processes to ensure decisions about their care were in their best interests.
● Several people were identified in care plans as having cognitive impairments that were likely to affect their

capacity to consent to their care, but the provider had not carried out capacity assessments. This meant they had not checked whether those people were able to continue consenting to their care.
● The provider had obtained signatures from people using the service as consent for COVID-19 testing, but we were not assured in all cases people had capacity to understand what they were signing for or agree to the procedure. Other documents about people's care had consent signed by people's relatives, but there was not always evidence they had the legal right to consent on behalf of their relatives. This can only be done lawfully with appropriate authorisation such as Lasting Power of Attorney.
● One person had a DoLS authorisation in place. There was no evidence the provider had considered applying for DoLS for other people who did not have or had lost the capacity to consent to their care. Some people had restrictive measures in place such as bed rails but the provider had not considered how these restrictions impacted on people's freedom and there was no evidence they had sought consent for this.
● Decisions about people's care, such as orders not to attempt resuscitation in the event of cardiac arrest (DNACPR) were not regularly reviewed to ensure they continued to reflect the best interests of people who did not have capacity to consent. We saw two of these that had last been updated in 2017 and 2018.

This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The service was in an older building which posed challenges to the provider in terms of meeting people's needs. The provider had taken steps to make this as accessible as possible. For example, there was no lift in the service but there was a stairlift and people with increased mobility needs had downstairs bedrooms.
● Some of the décor needed refreshing as it looked old and outdated. However, the provider was aware of this and some redecoration was taking place during our inspection.

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 good. At this inspection this key question has now deteriorated to requires improvement. 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

- Care plans were not sufficiently detailed for staff to provide personalised care that enabled people to make choices. For example, one person's care plan said they did not like using their mobility equipment, but the provider had not explored why this was or what alternatives they could offer to support the person to maintain their independence. However, care plans were regularly updated to ensure the information in them was current.
- Low staffing levels meant people had reduced choice and control over their care. For example, staff needed to complete most personal care tasks before 6pm as there were only two staff on duty after this. Staff told us they did not always have enough time to spend with people beyond carrying out basic care tasks, which meant people's care and support were not always personalised.
- Some aspects of care were not geared towards meeting people's choices and preferences. The service had a blanket procedure on how to support people with personal care, which did not consider how individual people preferred to carry out their personal hygiene routines.
- The provider did not always consider people's cultural or religious needs when planning care. Although care plans contained references to people's culture of origin, there was little or no information about what this meant to people or what support they needed to meet their needs in this area. One person's care plan stated their religion was important to them but they did not like the priest who provided religious support at the service. The provider had not attempted to find out why the person did not like this priest or find one the person was more comfortable with.

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.

- There was insufficient information in care plans to support staff to meet people's communication needs. Records showed some people had been diagnosed with conditions that may reduce their ability to communicate effectively but there was no information about how this affected people on a daily basis or how staff should support their communication needs.
- Information was not always provided in an accessible format. The provider had made some attempts to do this, for instance by adding pictures of food to menus. However, the pictures did not reflect all of the choices available which may have meant people did not always fully understand what options were available.

End of life care and support

● There was not sufficient planning in place to ensure people had a comfortable and dignified end to their lives. Some people had end of life care plans. These contained information about what people would like to happen after their death, for instance whether they wished to be buried or cremated. When we spoke with the registered manager it was clear they understood the main principles of how to care for people at the end of their lives. However, there were no details in care plans about the person-centred care people would like to receive in the last stages of their lives such as where they wanted to be and whether they wanted support to meet religious or cultural needs.

● Information was not always gathered in a timely way to meet people's end of life care needs. At the time of our inspection one person had very recently passed away. The end of life care section in their care plan stated staff were planning to explore with the person and their family what their needs in this area were. However, they had not done this despite the person having been diagnosed with a terminal illness several months earlier. The care plan did not contain any detail about how the progression of the illness was likely to affect the person in the terminal stages, for instance how they would manage pain.

The issues identified above were a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● At the time of the inspection the provider could not offer group activities or visits from relatives because people who used the service were self-isolating in their bedrooms due to an outbreak of the COVID-19 virus. As we were not able to observe these taking place, we looked for evidence that the provider had arrangements in place to meet people's needs in this area when the service was operating normally.

● Relatives told us the service had supported them to have as much contact with people as restrictions allowed. For example, before the current outbreak relatives had been able to see and speak to people through windows. Care plans included updates about how to meet people's family and relationship needs during the COVID-19 pandemic.

● The provider did not always consider people's individual preferences and interests when planning activities. One person's care plan stated they did not always like the activities offered to them but did not contain further information about what alternatives staff should offer according to the person's interests. However, relatives said outside of the COVID-19 restrictions, plenty of activities took place and one said the service "always celebrate things. Christmas, summer barbecues and they have parties" and told us staff did a good job of encouraging people to join in and socialise who were reluctant to do so.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy in place. They had not received any significant complaints since our last inspection.

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 good. 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.

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; working in partnership with others

- The registered manager told us they regularly asked people and their relatives for feedback about the service. However, because they did this informally and did not systematically record anything, there was no way for them to reliably monitor people's satisfaction with the service and whether they were improving the service in response to feedback.
- Relatives we spoke with were unaware of the serious and widespread concerns that had been raised about the service.
- The local authority and healthcare providers told us the provider had not informed them of the extent of the COVID-19 outbreak at the service, which meant they had been unable to work in partnership to reduce risks and ensure people's safety.
- Staff and relatives fed back positively about the managers and told us they were open and approachable. One relative said, "The manager is a joy." They felt the staff team worked well together.

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

- Relatives told us the registered manager communicated well with them and kept them updated about people's care. Generally they told us they were pleased with the service although they had not been able to visit inside the home for some time.
- Staff fed back positively about the management. They said the registered manager listened to them and acted on their feedback.

Continuous learning and improving care

- The service did not have an effective governance system to ensure people received safe, high quality care. The provider had not identified several of the issues we found during our inspection and in some cases did not know these were their responsibility. Although staff told us they had no concerns about the safety of the service before the COVID-19 pandemic, our findings showed the service had insufficient systems in place to prevent the rapid deterioration in standards that had since happened.
- No quality checks were recorded over the past year other than a medicines audit, which a pharmacist had completed, an infection control audit and some cleaning checklists. These checks were not consistently done in line with their prescribed frequency and contained several gaps where the checks had been missed

for several weeks or months.
● The provider had not followed up on issues the medicines audit identified in February 2020. Their own checks did not include action plans and we did not find evidence they had acted on any of the problems identified.
● The registered manager told us about how they monitored and improved the quality of care, for example discussing incidents with staff to help everyone learn from them and agree what they could do differently in future. However, because they did not record these, there was no system to ensure actions were completed or keep track of how well action plans were working.
● Records were not always sufficiently clear or complete for the provider to check people were receiving an acceptable standard of care and support. For example, daily notes often contained phrases such as "needs met," which did not indicate what care people had needed that day and whether care plans remained an adequate reflection of the daily care people needed.
● Some records were incomplete and out of date records such as care plans were stored alongside current ones, which increased the risk of staff accidentally referring to the wrong records and not providing care that met people's current needs and preferences. This was particularly true at the time of the inspection as the service was using a lot of agency staff who were not familiar with people and their care needs. The healthcare professional we spoke with told us records were disorganised and it was difficult for them to find the information they needed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● We were concerned the registered manager and provider did not understand the extent of their responsibilities and regulatory requirements. For example, there was no system in place to ensure cleaning was carried out on a daily basis. The registered manager told us staff took responsibility for this as they understood the risks of transmitting the COVID-19 virus. This meant the provider did not have adequate oversight of this to ensure they were fulfilling their duty to manage risks to people and staff appropriately.
● We were not assured leaders had kept their knowledge and skills up to date and to the standards required to provide good quality care. The registered manager and deputy manager told us they completed the same training as staff to ensure they were up to date with their knowledge and skills. However, they told us they had not had any additional training related to management, governance and leadership for several years.
● The provider did not have adequate contingency plans in place to manage risks. When we inspected there was a plan in place but this had not been updated to cover COVID-19 risks. The manager and deputy manager were both unwell and had been unable to work and nobody had reported to health authorities that 15 out of 16 people who used the service had tested positive for COVID-19. This meant authorities were unable to take action to support the service in a timely way, leading to standards of care deteriorating and people's needs being neglected.

The issues identified above indicate a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had failed to comply with their legal obligation to notify us of certain events that took place within the service, including deaths and events that stop the service from running safely. This potentially meant people were at increased risk because notification of these events helps us monitor the safety and quality of care and share information with other authorities when appropriate.

Failure to notify is a breach of regulations 16 (Notification of death of a person who uses services) and 18 (Notifications of other incidents) of the Care Quality Commission (Registration) Regulations (2009).

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to operate effective systems to prevent the neglect of service users. Regulation 13(1)(2)(4)(d)