MCKAT Care Homes Ltd

Charnwood House Nursing Home

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

Summary of findings

Overall summary

About the service
Charnwood House Nursing Home is a residential care home providing personal and nursing care to up to 35 people. The service provides support to older people, people with a learning disability, mental health, physical disability and people living with dementia. At the time of our inspection there were 21 people using the service.

Charnwood House Nursing Home accommodates people in one adapted building over four floors.

People's experience of using this service and what we found
Despite the positive feedback from relatives, we found a number of shortfalls during the inspection which the provider had not identified through their own monitoring systems. The provider responded well to our feedback, both they, and the registered manager were highly motivated to make improvements to the service.

People's individual risks were not always comprehensively assessed to guide staff on how to keep people safe. People were not always protected from abuse or the risk of harm; not all staff had completed necessary safeguarding training and referrals were not always made to safeguarding authorities as required. An effective system was not in place for reporting and reviewing accidents, incidents and near misses involving people. People's medicines were not always safely managed, this meant people were at risk of receiving medicines which may not meet their current needs.

Environmental issues were found around building maintenance and cleanliness. We made a recommendation to improve the environment for people living with a learning disability and dementia. Relatives of people told us that the home was in need of renovation and decorating. Some equipment and furniture were in a poor state of repair. We found building waste that was partially blocking fire escapes and could be viewed from communal areas and a person's bedroom. People were not always protected from infection due to the cleanliness of the home and staff not always using PPE (Preventative Protection Equipment) appropriately.

People and their relatives were not meaningfully involved in creating or reviewing their care plan, this meant their choices, preferences and wishes were not fully captured. People were not provided with a range of meaningful activities, inside or outside, of the home to reduce social isolation, combat loneliness and improve wellbeing. The provider had not ensured the needs of people who lived with dementia and a learning disability were planned and fully understood.

The provider had not ensured all requirements under the Mental Capacity Act (MCA) and authorisations under the Deprivation of Liberty Safeguards were fully met. Not everyone was supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support good practice.

People were provided with a varied diet of food and fluids to meet their hydration and nutrition needs. People were very positive about the food and drink offered by staff.

Staff had been recruited safely to the service and had a DBS (Disclosure and Barring Service) check to make sure they were safe to work with adults. The provider recruited staff from different backgrounds, with a range of skills and experience. Staff were provided with induction training and supervision to support them in their roles. We made a recommendation about supporting staff to develop their communication skills.

Relatives were very positive about the kind and caring nature of staff and registered manager. The registered manager and staff spoke positively about their caring roles with people and we observed caring interactions. Relatives felt able to raise any concerns with the registered manager and found them approachable. The registered manager felt supported by the provider, both were committed to improving the quality of the service offered to people.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic. We found this guidance had not been considered when planning the care of people in the home living with a learning disability.

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 under a new provider on the 14 February 2022 and this is the first inspection. The last rating for the service under the previous provider was Good (Published 13 November 2018).

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the support provided to people who could become distressed. This inspection examined those risks.

This service had not been inspected since a change in registration; therefore, this inspection was also carried out to gain assurances about the quality of care and systems used to monitor and manage the service under the new provider.

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment of people, safeguarding, consent, person centred care and the governance of the service at this inspection. We made recommendations to improve the environment and staff communication.

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

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

Follow up
We will request an action plan from the provider to understand how they will make improvements and by when. We have signposted the provider to other agencies to support them to make improvements. 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 always effective. Details are in our effective findings below.	**Requires Improvement**
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 always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Charnwood House Nursing Home

Detailed findings

Background to this inspection

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

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 2 inspectors and 2 Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

At the time of our inspection there was 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. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke to the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke to 8 staff including the clinical lead, 1 nurse, 1 senior carer, 2 carers, 1 housekeeper, 1 laundry assistant and the cook. We spoke to 9 people who use the service and 7 relatives of people who use the service.

We reviewed a range of care documentation, risk assessments and medicine records for people. We looked at staff recruitment files and documents around staff training and support. We reviewed a variety of records relating to the management of the service, including policies and procedures and quality assurance records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us .

We spoke to professionals who worked with the service to gain their feedback.

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 provider. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding incidents were not always identified and reported to keep people safe from harm. On inspection we identified 5 incidents between people which had not been reported to the local authority safeguarding team, who were responsible for investigating concerns of abuse. We also found several examples where injuries to people, such as falls or unexplained bruises, had not been reported or investigated by the management team. This meant measures could not be put in place to safeguard people and help prevent incidents from happening again. We raised several safeguarding issues with the local authority during our inspection as a result of this.
- The lack of reporting safeguarding incidents meant there were missed opportunities to work with other professionals to review and mitigate such incidents in order to keep people safe.
- The provider had not ensured that all staff had up to date safeguarding training and awareness to support them in recognising potential abuse. Of the 19 training records we reviewed, only 11 staff had completed or had refresher training in safeguarding. Conversations with staff showed there were gaps in their knowledge around this.
- At times people were at risk of being hurt when other people became distressed. There were no risk assessments in place to guide staff on how to keep people safe from harm when others became upset.

The provider had failed to ensure people were protected from the risk of abuse and report safeguarding incidents to the relevant authorities. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Assessing risk, safety monitoring and management ;

- Where the provider had identified people were at risk of harm, they had not put in place clear guidance for staff about the action they needed to take to keep people safe. This included where people had been identified as being at risk of choking, falls, leaving the service unsupervised, experiencing distressed behaviours, pressure ulcers and diabetes.
- Risk assessment of people at risk of falls and skin deterioration was poor. Where people had been scored as at high or medium level of risk, preventative measures were not always in place. For example; incident records showed 1 person had sustained more than 1 fall recently and risk assessments had not been reviewed to show what preventative measures had been put in place and whether they remained effective.
- There was inadequate analysis of accidents, incidents and near misses to reduce the risk to people. A review of records showed incidents had not always been reported and reviewed to facilitate learning and a review of the management of risk. This meant the provider had not always learnt from previous incidents and put measures in place to mitigate the risk to people.
- Analysis of falls did not take place to ensure people's wellbeing and prevent future falls. Whilst falls were

reviewed by the registered manager monthly, further analysis to identify themes and trends had not been completed. For example; looking at the times and locations where falls occurred to support the management team to identify risks and put measures in place to mitigate them.
● Guidance to support people at risk of choking to eat and drink safely were not always in place. Not all staff had received or refreshed their emergency first aid training to know how to respond if people were to choke. This means that if people were to choke, staff may not respond to their needs appropriately.
● Personal emergency evacuation plans for those people who might become anxious did not contain correct information about the support people would require to evacuate the building in an emergency. This placed people at risk of receiving inappropriate and unsafe support if the home required evacuation.
● Risks within the environment were not mitigated. We found building waste material obstructing fire exits, broken radiator covers, perished furniture and equipment not in a good state of repair.

Risks to people had not always been effectively assessed and managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took immediate action following our inspection to review people's risk management and improve the environment.

Using medicines safely
● Some people were prescribed pain patches. Information was not available to guide staff how to rotate the patches on people's bodies so that it would not be applied consecutively on the same site. This increased the risk of people developing a skin reaction.
● Good practice guidance was not always followed when staff recorded the administration of people's medicines onto Medicine Administration Records (MAR). This included ensuring medicines prescribed were on the MAR, and that medicine stock and discontinued medicines were clearly recorded. This increased the risk of medicine errors occurring.
● The provider had not ensured that people's medicine's profiles were up to date and reflective of how they like to take their medicines. This placed people at risk of being administered medicines incorrectly or not in line with their needs.
● The provider did not ensure that people's PRN (as prescribed medicines) and homely remedies' protocols were reviewed and agreed with the GP. This placed people at risk of receiving medicines which were not suitable for their needs.
● People's creams and topical medicines records were not always completed to show they were administered as prescribed. Topical Medicine Administration Records (TMAR) were not consistently used for all people by staff. We found prescribed creams with no pharmacy labels on, therefore staff could not be sure who they belonged to. This placed people at risk of receiving medicine or creams not suitable for their needs.

People's medicines were not safely managed and administered at all times. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately to these concerns after the inspection. They completed a medicines audit of all people's medicine and reviewed people medicine records.

● Staff had received training in medicines management and medicines administration was completed by registered nurses.

Preventing and controlling infection

● Staff were not using PPE effectively and safely. For example, we found staff wearing kitchen PPE whilst undertaking cleaning, and we found staff to be walking around the home with PPE on which increased the risk of cross contamination.
● We found aspects of the home to be unclean, for example; cobwebs on the ceilings, dust and strong smells.

Good infection control practices were not always followed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● 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.
● The provider followed national guidance for visitors coming to the home.

The provider responded immediately to these concern after the inspection. They completed a deep clean of areas where we found concern. We have also signposted the provider to resources to develop their approach.

Staffing and recruitment
● The provider did not use an evidence-based tool to determine staffing levels in accordance with people's needs and the environment. This meant they could not monitor when people's needs changed and be assured staffing levels remained sufficient to meet people's needs. For example, we saw staff that were working in areas of the home supporting people, were not always aware people in other areas of the home were calling for assistance due to the layout of the building.
● We reviewed recruitment files and found that the provider was operating safe recruitment practices. The provider completed DBS checks on staff prior to them providing care. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● The provider was actively recruiting staff and were working towards the vision of a permanent staff team, so people were supported by staff that knew them well.

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.

This is the first inspection for this newly registered provider. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.

● Appropriate legal authorisations were in place for those people deprived of their liberty. The provider had not ensured that conditions relating to people's DoLS authorisations were always being met. We found people were not provided with activities as part of their DoLS conditions. We have described the lack of meaningful activity for people in more detail in the Responsive key question.
● Not everyone was being supported in a way that enabled them to have choice and control in their daily lives. The bedroom of one person who lacked mental capacity to make some day to day decisions was very bare and dirty. Staff told us they had removed the person's belongings due to hygiene reasons. A mental capacity assessment and best interest decision record was not available to show how the decision to withhold the person's belongings had been made to support the person's rights.
● We found consent forms that were signed by those who lacked capacity to make the decisions they were consenting to without appropriate mental capacity assessment and best interest decisions having been made.

The provider had not always ensured that they were following good practice when working within the principals of MCA. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff sought the consent of people prior to providing them with personal care or support. Staff were

observed to offer daily choices around food and drink.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
● The registered manager assessed people's needs before they received a service. This supported the provider to understand people's needs and risks before they moved to the home.
● However, people were not always being supported in line with best practice guidance as risk assessments and care plans were not being reviewed effectively to help ensure people's needs and choices were assessed regularly.
● One person living with a learning disability would have benefitted from having their needs relating to their learning disability reassessed in accordance with the principals of the 'Right support, right care, right culture' statutory guidance. Their support plans did not set out their current needs, strategies to enhance independence and how their longer-term aspirations had been considered.
● Care plans for people with dementia did not include assessments of their communication support and sensory needs. Of the 19 staff training records we reviewed, only 1 had completed dementia awareness training to support them to understand the needs of people living with dementia.

People's individual needs had not always been assessed and planned for. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The environment was tired and in need of decoration and maintenance. We found people' s bedrooms were not always personalised, and they lacked a homely feel.
● Adaptations had not always been made to the environment to support those people with dementia or learning disability. For example; we found parts of the home to be noisy, there were limited signs, guidance or contrasting colours to help people orientate themselves to their surroundings. We observed some people to find the noise within the home distressing and some people getting lost due to confusion and the signs not being understood.

We recommend the provider reviews the environment with the needs of people living with a learning disability and dementia in mind.

The provider responded immediately to our concern and has begun a plan of redecoration in line with people's choice.

Staff support: induction, training, skills and experience
● We found when speaking to some staff for whom English was not their first language, they were not always able to describe people's needs or communicate their responsibilities and training knowledge clearly.
● The provider recruited staff from a diverse backgrounds, skills and experience. Staff were positive about team morale, felt they learned from each other and worked well as a team.
● Staff received an induction, ongoing training and competency-based assessments to support them in their roles and ensure their skills were current. A staff member told us, "The training is good." The provider had identified future training needs of the team to enhance their skills further.
● Staff received regular support this included; supervisions, appraisals, training and team meetings.
● The registered manager received support from the provider in their role and in the running of the service.
● Relatives spoke positively about the staff employed by the provider. Relatives told us; "The [staff] are always friendly and jolly" and "[The registered manager] and [manager's] team are doing a fantastic job ." We observed positive interactions between staff and people during lunch time observations and medicine rounds.

We recommend the provider review the language and communication support and training provided to staff.

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

● Health professionals told us that they were not always contacted promptly by staff when people required medical attention, as staff might not always recognised people's deteriorating health.

● People were supported to attend routine health related appointments and to access health care services. For example, dentist and opticians' appointments.

● Staff worked in collaboration with a range of health professionals to support people to access healthier lives and health care services. This included; Health assessors, GP, Positive behaviour support teams and District nurses.

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

● People living with diabetes did not have information in their care plans relating to their dietary requirements to ensure they made food choices that would keep their blood sugar stable.

● Staff did not always record people's weights when they had been identified as a risk of malnutrition and required their weight to be monitored. When weight had been recorded, the record did not show that action had been taken when people had been identified as losing weight.

● People were provided with regular meals, snacks and fluids by staff to ensure their nutrition. We observed a good selection of food on inspection. A person told us; "Good food [at the service]. Plenty to eat!" A relative told us; "[person] speaks very highly of the food and when [relative] been there, the carers are in and out with drinks and biscuits."

● Staff to supported people to eat and drink in a calm, compassionate and engaging manner when needed. During lunch time we saw staff making good eye contact with people and checking they were comfortable and had everything they needed.

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.

Supporting people to express their views and be involved in making decisions about their care
- People and their relatives were not always involved in the development and reviewing of people's care plans . Care plans had limited information about people and relatives' voices, wishes and feelings as part of care plan reviews. This meant that people were not always involved in directing staff and deciding how they would want their care delivered.
- People had not always been asked about the activities they would like to be offered in the home. We found some activities which were offered to not be appropriate to all people. Please see our detailed findings in the Responsive key questions.
- Relatives were kept informed about people's care. Relatives told us that staff kept them up to date via telephone calls, emails or in person on an as needed basis.
- The provider had identified prior to our inspection this was an area they wished to improve in the future.

Ensuring people are well treated and supported; respecting equality and diversity
- People were not always provided with care which was inclusive and recognised their equality and diversity needs. We found people living with dementia and one person with a learning disability whose needs were not fully understood and supported by staff in an inclusive manner. For example; one person living with dementia communicated through shouting, staff did not understand their communication needs, and they were therefore not supported to socialise in communal areas.
- Relatives of people spoke positively about staff providing respectful and dignified care. Relatives comments induced; "Overall very pleased with the care [person] is getting there as [staff] seem to be taking care of [person] very well" and "[staff] are so kind and treat [relatives] well."
- Staff and the registered manager spoke positively about their caring roles. We observed calm and caring interactions from staff towards people in communal areas.

Respecting and promoting people's privacy, dignity and independence
- People told us that they did not always receive compassionate and gentle personal care from staff. Some people found staff to be gentle when providing personal care, some people felt that staff were a bit rough at times. We have shared this feedback with the provider who told us they would look into this concern.
- Relatives of people felt that staff provided respectful and dignified care to people. A relative told us, "The best thing about [the service] is just the way [staff] treat [person] with respect as [person's] not a thing or a patient without a personality, [staff] treat [person] as an individual."
- People's dignity and confidentiality was respected when staff were providing personal care.

Requires Improvement

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 as inadequate. This meant services were not planned or delivered in ways that met people's needs.

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 were not provided with a range of meaningful activities to enhance their wellbeing , reduce social isolation and decrease distressed behaviour. The activity records for people cared for in their bedrooms did not show they were offered meaningful activities. People cared for in bed told us that they did not receive one to one time with staff to reduce social isolation. The registered manager confirmed this and agreed to look into activities for people cared for in bed.
- Some activities which were offered were not accessible and sometimes not inclusive of those living with dementia or a learning disability. For example, loud music was played throughout the day which was distressing to some people.
- The service did not offer a full range of multi-cultural activities, events and celebrations to accommodate the needs of all the people living in the home. One person told us, "Before [person] came [to the home], [person] had loads of things to do. [person] did tai chi." Which was an important aspect of their culture.
- People were not offered activities outside of the home to promote socialisation and wellbeing. We observed limited activity taking place for people as part of this inspection. People told us, "[Person] want to go for a walk. [Person] haven't been nowhere." Another person told us "[Staff] don't let you out to do any shopping. [Person] want to go and get a coat or a dress. [Person] just sit down." The provider confirmed outings are not currently taking place, but they would review this for the future .

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs

- People's needs, preferences and choices were not sought and reviewed by the provider. For example; choice of toiletry products used when washing, what people liked to wear, and the time of day they would like to wake up. This meant staff may not fully understand people's preferences and people may therefore not receive care that met their needs .
- All people had not always been given an opportunity to share their wishes around their end of life care. This meant staff would not know what people's end of life wishes were and who should be contacted in the event someone required end of life care.
- Staff had not always been responsive to the needs of people who have a learning disability as they were not fully understood. The provider had not worked in collaboration with other agencies to be responsive to this person's needs and ensure staff were not being restrictive in their practices.

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.

● We found people living with dementia and one person with a learning disability had not been supported by the provider with accessible information, such as pictorial cards to aid their understanding and decision making.
● Out of 19 staff, only 9 had completed or updated their training in relation to supporting people with learning disabilities to help them understanding the communication needs of people living with a learning disability.

All the concerns noted above showed that people's care had not always been planned to meet their individual 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.

The provider responded immediately to these concern after the inspection. They have developed a menu of activities for people and are reassessing people's activity needs across the service.

● We saw staff supporting people to remain comfortable. For example; offering a blanket to keep them warm, providing tea and biscuits.
● Staff spoke positively about their caring roles and felt that they knew people well. Relatives told us they felt staff knew people well.

End of life care and support
● At the time of inspection, the service was not supporting people at the end of their life. Nursing staff had been trained in delivering this care.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy and the registered manager had a system for reviewing complaints and responding to concerns.
● Relatives felt able to share any concerns they had with the registered manager and staff listened to concerns and acted upon complaints. A relative told us, "If [relative] had any concerns [relative]I would bring them to the attention of the manager."

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

- There was a lack of governance processes and systems in place to help ensure the safe running of the service. Without these systems, the provider and registered manager could not be proactive in identifying issues and risks in a timely way and acting on these.
- The poor quality of risk management plans relating to people's individual risks and the environment had not been identified as an area for improvement until we raised this as a concern. We were not assured the registered manger and staff were able to independently identify and manage quality concerns to keep people safe.
- The provider and registered manager had failed to identify that they were not operating an effective accident, incident and near miss system. Not all accidents and incidents had been reported and scrutinised, therefore they did not have oversight of all safety incidents that had occurred in the service. This means that action could not be taken to keep people safe and learning shared with the team.
- The provider and registered manager had not identified, through their own monitoring systems, that the checks they had put in place to monitor environmental risks had not been effective. Systems had not identified the areas of concern we found in relation to building maintenance, cleanliness and equipment repair.
- The registered manager did not understand all their regulatory responsibilities; there were no processes in place to ensure safeguarding incidents were identified and reported to the local authority safeguarding team.
- The activities on offer to people had not been routinely reviewed and prompt action had not been taken to ensure all people had activities tailored to their interests and preferences.
- People and relatives were not always given an opportunity to provide formal and informal feedback about the service and identify improvements they felt might be needed. This meant that the registered manager could not be assured about the views of all staff, residents and relatives in relation to the running of the home.

The failure to implement and operate effective systems to maintain the safety and the quality of the service placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Providers are required to act in an open and transparent way when people come to harm and to notify CQC of significant events without delay. The provider had failed to notify CQC of significant events that happened in the service as required by law. This included allegations of abuse and an authorisation of DoLS.

● Although we saw an example of the duty of candour being used following the incident which triggered this inspection, the systems used by the management team to scrutinise accidents and incidents were not effective. This means the provider could not always determine whether they needed to notify CQC or if an apology to people would be required.

The registered manager failed to complete all statutory notifications to the CQC. This was a breach of regulation 18 (Notification of other incidents) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager took immediate action following our inspection. They made retrospective statutory notification to the CQC DoLs and safeguarding.

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

● Staff were encouraged to attend regular team meetings and supervisions to understand the service and share practice knowledge. Staff were positive about the support they were given by the registered manager.

● Staff, people and their relatives spoke positively about the registered manager as a leader of the service. A relative told us; "[Registered Manager] is really caring and very understanding and knowledgeable". A staff member told us; "[The registered manager] is a really good [to work with]".

● The registered manager was supported by the provider. The registered manager and provider told us that they have a good working relationship, and both want to improve the service so that it can be the best.

Working in partnership with others

● The registered manager and staff worked in partnership with other agencies and professionals to support people. Feedback from other professionals is that the registered manager and staff are engaging and welcome learning.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager failed to complete all statutory notifications to the CQC. This was a breach of regulation 18 (Notification of other incidents) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs and choices were not always assessed and understood so that they would individualised care. People were not provided with meaningful activities to reduce the risk of behaviours that challenge. The provider had not ensured personalise planning of care to meet the needs of people. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Principals of the Mental Capacity Act were not consistently followed by the provider. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people relating to their care and the environment were not always assessed and mitigated. 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:

We issued a Warning Notice to ensure the provider made this improvement within a specified timescale.

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 Systems relating to safeguarding did not ensure all incidents of potential abuse was reported and investigated. 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:

We issued a Warning Notice to ensure the provider made this improvement within a specified timescale.

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 Systems to monitor quality and risk in the service were not effective. 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:

We issues a Warning notice to ensure the provider would make these improvements within a specified timescale.