SHC Clemsfold Group Limited

# Horncastle Care Centre

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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| Is the service safe? | **Inadequate** |
| Is the service effective? | **Inadequate** |
| 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:

•Horncastle Care Centre is a residential care home that provides nursing care and support for up to 20 people. Some people had neurological conditions, physical disabilities, a learning disability and other complex health and communication needs. There are two 'units' named Willow and Maple Lodge each with their own dining area. At the time of our inspection there were 19 people living at the service. Four people were receiving short term care.

•Horncastle Care Centre is owned and operated by the provider Sussex Healthcare. Whilst Horncastle Care Centre is not part of the investigation, services operated by the provider had been subject to a period of increased monitoring and support by local authority commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. The investigation is on-going and no conclusions have yet been reached.

•At the previous inspection in April 2018 we found five breaches of regulation in relation to safe care and treatment, protecting service users from abuse, staff training, adaption of the home and governance. At this inspection we found these breaches continued. We also found new breaches of regulations relating to person centred care, dignity and consent.

•The service had not been developed and designed in line with the values that underpin the 'Registering the Right Support' and other best practice guidance. These values include choice, promotion of independence and inclusion. These values were not always seen consistently in practice at the service. For example, some people were not treated with dignity and other people were not being supported to attend meaningful activities and access the community often enough. For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

- All of the areas of concern we found during this inspection had already been highlighted to the provider following inspections of some of their other services. Learning had not been effectively shared to ensure that people living at Horncastle Care Centre received consistently safe, effective and well-led care.

People's experience of using this service:

• A number of aspects of the service remained unsafe. This included risks associated with constipation, epilepsy, skin integrity and behaviour management.

•Some people were at risk as some risk assessments were not in place. Risk assessments that were in place were not always effective in reducing the possibility of harm. Staff had not always taken steps to keep people safe as there were failings in meeting some people's health needs such as bowel, epilepsy and skin integrity management.

•People were not consistently protected from abuse as concerns had not been identified by the provider.

•Learning from incidents had not been consistently implemented. Most of the areas of concern we found during this inspection, such as risks associated with health needs not being reduced and poor-quality auditing, had already been highlighted to the provider following inspections of some of their other services.

•The provider failed to ensure agency care staff had the necessary training they required to carry out their

role, such as training about epilepsy and people's specific diagnoses.
•□Adaptions had not been made to ensure people could move independently around the home.
•□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; the policies and systems in the service did not support this practice.
•□People were not consistently treated with dignity and the language some staff used was not person centred.
•□People did not always receive personalised care. Some people were not provided with a range of person-centred activities.
•□The previous inspections rated the well led domain as 'Requires Improvement'. At this inspection the rating has reduced to Inadequate, therefore, leadership at the service was not effective.
•□Quality audits had not been effective in highlighting and putting right all the shortfalls we found at the last and this inspection.
• There were enough staff deployed to meet people's needs safely and the provider operated safe recruitment systems for permanent staff employed.
•□We observed some people receiving caring and kind support by staff who knew them well.
•□People told us that they liked their staff.
•□People had enough to eat and knew how to make a complaint.

More information is in the detailed findings below.

Rating at last inspection:

At our last inspection in April 2018, the service was rated "requires improvement" overall with a requires improvement rating in the safe, effective and well led sections, and a good rating in caring and responsive domains. Our last report was re-published on 5 February 2019 (after additions were made to include information about provider-level enforcement action by the Commission). This is the first time this service has been rated Inadequate.

Why we inspected:

We received information of concern alleging abuse and mistreatment of service users living at Horncastle Care Centre. We informed the local authority safeguarding team and the police were made aware. No conclusions have been reached by their investigations at this point.

Enforcement:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

Follow up:

The overall rating for this service is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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|---|---|
| **Is the service safe?**<br>The service was not safe.<br>Details are in our Safe findings below. | **Inadequate** |
| **Is the service effective?**<br>The service was not effective<br>Details are in our Effective findings below. | **Inadequate** |
| **Is the service caring?**<br>The service was not always caring<br>Details are in our Caring findings below. | **Requires Improvement** |
| **Is the service responsive?**<br>The service was not always responsive.<br>Details are in our Responsive findings below. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not well-led<br>Details are in our Well-Led findings below | **Inadequate** |

# Horncastle Care Centre

**Detailed findings**

## Background to this 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out over three days by two inspectors, a specialist nurse advisor and an expert-by-experience. The specialist nurse joined for the first two days of the inspection. They held knowledge and experience in supporting complex health conditions. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience had knowledge about care of adults with learning disabilities and autism and joined the inspection team on the first day only. A medicines inspector joined the inspection team on day two of the inspection. The third day of the inspection consisted of the same two inspectors only.

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. The registered manager was not present through the inspection, however an interim manager, who was new to the home responded to our requests and supported the inspection.

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

Notice of inspection:
This inspection was unannounced on the first day.

What we did:
We reviewed information we had received about the home since the last inspection in April 2018. This included details about the concerns we had received and incidents the provider had notified us about, such

as allegations of abuse. We require providers to send us at least once annually key information about the home, what the home does well and improvements they plan to make. However, as the inspection had been brought forward, due to concerns, on this occasion we had not made this request. We used all this information to plan our inspection. We spoke with the local safeguarding adults team and local health teams.

We spoke with three people using the service and two relatives. Due to the nature of some people's complex needs, we were not always able to ask people direct questions about the care they received. To obtain information about their experiences 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 spent time observing the care and support that people received during the morning, at lunchtime and during the afternoon over the course of the inspection.

During the inspection we looked at a range of records including: 13 people's care records, medicine records, records of accidents, incidents and complaints, audits and quality assurance reports, rotas, four staff recruitment files, and supervision and induction paperwork. We also spoke with four members of care staff, two registered nurses, the deputy manager and the interim manager. We provided feedback of our findings to the deputy manager, interim manager and the regional operations director.

Inadequate

# Is the service safe?

## Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

When we last inspected the service in April 2018 we found the provider was in breach of regulations in relation to managing risks and had failed to safeguard people from the risk of abuse. At this inspection, we found continuing breaches of regulation as care provided to people had deteriorated and was not consistently safe.

Assessing risk, safety monitoring and management
•People were not consistently protected from the risk of harm. People with a learning and physical disability can be prone to bowel problems such as constipation. Most people living at the service were at risk of becoming constipated and were reliant on staff to manage this risk. Failure to support people adequately with managing constipation can lead to a person experiencing poor physical health. We found examples where action had not been taken by staff when people had not opened their bowels, which placed them at risk from harm.
•One person's bowel chart stated they had no bowel movement for three consecutive days. Their elimination care plan failed to inform staff what they should do if the person went for prolonged periods of no bowel movements. They were not prescribed any medicines to relieve constipation. On the fourth day the person experienced an epileptic seizure. Their care plan confirmed constipation could be a trigger for epilepsy. This meant the lack of action taken may have triggered them to suffer a seizure which placed them at risk from harm. Their bowel chart also showed another example where they had no bowel movement for four days and no actions taken. Both episodes were in the last three months.
•We fed back the lack of guidance and actions taken to the provider's management team. We also queried why the person was not prescribed any medicines for constipation if this was a known area of risk. The managers spoke with the person's GP who later prescribed them with a medicine to assist in relieving any further episodes of constipation.
•The interim manager also completed further guidance for staff which contained the necessary information required to meet the person's bowel and epilepsy needs. However, this had not been identified by staff or managers prior to this inspection.
•Another person was prescribed a variable dose of medicines for constipation. We noted on one occasion they had also experienced no bowel movement for four days. On this occasion they were not administered the maximum dose of their constipation medicines which may have relieved them. This person also had a diagnosis of epilepsy. This meant not all actions were taken by staff to relieve the person from constipation and potential discomfort, and to minimise the risks of them having a seizure.
•We fed back this concern and three other concerns on behalf of other people at risk of constipation to the management team. During the inspection they continued to review and amend the issues we had highlighted.
•Risks associated with constipation have been raised at inspections of some of the provider's other services. The provider had not ensured that this had led to safer bowel care at Horncastle Care Centre.

•In addition to unsafe practices in association with the link between constipation and epilepsy, we also remained concerned about how seizures were being recorded. Epilepsy records were a concern highlighted at the last inspection. Staff told us it was not always the person who observed the seizure who completed an epilepsy record. Epilepsy records we read showed this was usually completed by registered nurses and/or senior carers who may not have observed the seizure. This is not good practice as there was a risk important information about how the person presented at the time could be missed. Whilst we could not determine impact of this practice it is essential accurate epilepsy records are maintained as they are a guide for external health professionals when making health decisions on behalf of a person, such as a change in medicines.
•Four people received regular short-term care at Horncastle Care centre. Three out of the four had a diagnosis of epilepsy. One person's care plan described them as having a possible six epileptic seizures per day. Records showed they had visited the service once or twice a month between April and November 2018. They stayed between three and five days each visit. However, there was no epilepsy care plan in place to state how they presented at the time and what actions staff must take to mitigate risks to their health. There were also no accessible records of any seizure activity they had experienced during any previous visits.
•Another person receiving short term care was prone to fractures due to their health condition. They were also diagnosed with epilepsy. It was important staff knew how to support them when they were having a seizure to ensure the risk of fractures were mitigated. However, they had no epilepsy care plan to guide staff of what to do and no record to demonstrate whether any seizures had taken place on their last visit.
•Risks associated with epilepsy have been raised at inspections of some of the provider's other services including Horncastle Care Centre in April 2018. The provider had not ensured that this had led to safer epilepsy care at Horncastle Care Centre.
•We were unable to meet and speak with people receiving short term care or their relatives. However, the lack of guidance for staff and records available meant the provider could not demonstrate that they had assessed the risks to people from epilepsy and whether their needs were being met. The interim manager told us they would review all epilepsy care planning for people receiving short term care.
•Most people were at risk of pressure damage to their skin due to their physical health. This meant it was important people's skin integrity was regularly monitored for any changes. Specialist mattresses had been purchased on behalf of some people to help prevent pressure sores developing. Specialist mattresses are usually set in accordance with a person's weight to achieve maximum benefit from them. However, we found this not to be the case. Some mattresses were set at levels which may have been uncomfortable for the person sleeping on them and placed them at an increased risk of skin pressure damage. Checks were not carried out by the provider to ensure mattresses were set correctly.
•For example, one person who, at the time of this inspection had a pressure wound, had a specialist mattress on their bed. They weighed 69kg however the mattress was set for a person's body weight of 140kg. Records also stated they regularly refused to be re-positioned by staff at night time. This meant it was even more important the mattress was set correctly to mitigate the risk of further skin damage. We could not establish how long the mattress had been set incorrectly or whether this had caused the person discomfort or affected their pressure wound. Records for people who required support to be repositioned throughout the night did not state whether mattress pressures had been checked and adjusted if needed.
• We continued to check mattress settings with a registered nurse and the provider's physiotherapist. Some mattresses had settings which stated a number between one and seven. We queried what the numbers meant. However, neither the registered nurse or physiotherapist knew what the numbers equated to. Therefore, the provider could not demonstrate they were set correctly for each person. One person's moving and handling guidelines stated staff must check the pressure of their mattress. However, this would not have been possible as staff were not aware what the settings meant. We asked for immediate action to put this right.
•On the third day of the inspection we sampled and checked some mattress settings and found they were set in accordance with people's weight. Risks associated with skin integrity have been raised at the last

inspection at Horncastle Care Centre and at inspections of some of the provider's other services. The provider had not ensured that this had led to safer skin integrity care at Horncastle Care Centre.
•Some people were described as having behaviours which may challenge others. We found care records lacked a positive behaviour support approach or proactive strategies that could support staff to meet this need safely.
•For example, we asked the deputy manager at the beginning of the inspection whether there was anybody who presented behaviours that we needed to be aware of. They discussed one person yet stated they had very few incidents now. However, we observed throughout the inspection they were both verbally challenging to other people living in the same unit and physically challenging to staff. We observed them slap one staff member around the face. Mostly, staff failed to engage with the person. They used approaches that may have escalated behaviour rather than de-escalated and calmed a situation down such as, "No [named person]" instead of trying to distract their attention or engage with a meaningful activity.
•We read accident and incident reports. One incident two months earlier described a situation where the person had pulled a visiting health professional's hair. Their care records referred to hair pulling. However, it did not guide staff on what to do if the person pulled their hair. The incident had also failed to influence a change in staff's behaviour such as tying their hair back, as some staff had their hair down. Despite inspectors asking about behaviour that may challenge, the management team did not advise inspectors to tie their own hair back to prevent any challenges by this person.
•We spoke to the management team about this on the first day of the inspection. They assured us work had commenced with the provider's autism lead which included the training of staff. The provider's autism lead was visiting on the third day of the inspection. They shared they were in the process of getting to know the person. However, our observations concluded at the time of this inspection, that risks presented by the behaviour of this person were not being safely managed as improvements were yet to take place.
•Another person, displayed behaviours which may challenge others. Their care plan did not give any analysis as to the reasons why the person may behave in a certain way. The person received one to one support, had complex communication needs and care records stated they get 'bored' quickly. Yet there were no personalised communication aids for staff to use to assist them in letting the person know what activity was taking place and what was coming next.
•Behaviour monitoring charts failed to provide meaningful descriptions as to what happened and only provided general comments, '[Named person] became aggressive'. There was no indicator of any triggers, what the aggressive behaviour looked like and whether it had impacted other people or staff. This meant the provider had not fully explored the reasons and outcomes from the person's behaviour in order to ensure the person was supported in the best way to meet their individual needs.
•Risks associated with behavioural management have been raised at inspections of some of the provider's other services. Learning from CQC reports had not been used at Horncastle Care Centre to ensure safer and more person-centred care was delivered.
•At the last inspection we spoke to the provider about the importance of mitigating choking risks connected with the texture of people's meals. At this inspection we found some people remained at risk of choking. We found conflicting information within guidance which increased the risk of people not receiving safe care.
•For example, one person received short term care and stayed at the home each month. They had a learning disability. A speech and language therapist had provided guidance for the person to avoid certain foods due to risks of choking. It also stated staff supervision should be provided to them whilst eating other named foods. Yet this information was not referred to in their care passport which is a document which should travel with a person if they were admitted to hospital. This meant hospital staff would not have been given information to keep the person safe. We shared this information with the provider.
•Risks associated with choking have been raised with the provider at other inspections. This has not led to consistently safe improvements to ensure significant risks are mitigated. The interim manager told us they would ensure all care documents stated the correct guidance in relation to the person's texture of food.
•We also spoke to the provider at the last inspection about people at risk of dehydration as they had failed to

demonstrate all people were receiving their recommended daily amounts of fluid. At this inspection we found further improvements were required on behalf of one person. They received short term care from staff and due to a health condition needed staff to ensure they received a recommended fluid amount daily. However, fluid charts we sampled did not demonstrate the person was meeting their recommended daily fluid amount consistently and in accordance with their care plan. We were unable to meet this person or speak with their relative and staff could not confirm whether that had or had not received the correct amount of recommended fluids. This meant they were at risk of not having their hydration needs met.
•Discussions with the provider at other inspections about the risks associated with hydration at other inspections has not led to improvements to ensure this need is being met consistently.

Learning lessons when things go wrong
•The provider did not always learn lessons to ensure people received consistent safe care and treatment.
•This included a failure to improve how risks were being managed in relation to constipation, epilepsy, choking, hydration and skin integrity. We have provided examples of this earlier in this inspection report.

Using medicines safely
•People living at the home were prescribed medicines. We found some gaps in guidance accessible for staff supporting people.
•For example, one person was prescribed a medicine to help them sleep. We noted there was no care plan or guidance within the Medicine Administration Record (MAR) to support staff in making a safe decision about when to administer this. We discussed this with the management team. They referred us to meeting minutes where a GP had stated they must only be prescribed this medicine after they had experienced three nights of not sleeping adequately. This information had not been written in a care plan however. We noted the medicine had not been administered excessively, however, we found the person had on one occasion been administered the medicine without any record of them not sleeping for three nights. Records showed the person was away and not staying at the home the three nights prior to the administration of this medicine. There was no record to show that the person had not slept for the nights spent away from the service, so there was no documented reason for staff giving them the medicine. The interim manager agreed work was needed to ensure registered nurses worked in accordance with the GP's guidance to ensure safe practice was followed.
•Some people who had a diagnosis of epilepsy were prescribed emergency epilepsy medicines, in case of seizures. Registered nurses were trained in managing medicines and able to administer such medicines in the event of a person experiencing prolonged or multiple seizure activity.
•One person had guidance in place to state the amount of emergency epilepsy medicine's registered nurses could administer prior to calling emergency services such as the paramedics. We spoke to the registered nurse on duty about this. They told us they could administer less emergency epilepsy medicines than stated in the guidance whilst waiting for emergency services to arrive. This meant there was a risk not all the person's prescribed emergency medicines would be administered to them when they needed it. We fed this back to the management team who told us they would review the guidance and ensure all staff were aware of what procedure must be followed.

The failure to ensure effective risk management, to monitor and analyse incidents and to ensure that suitable actions were taken to make improvements and prevent further occurrences is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Other aspects of medicines were managed safely. This included the safe storage of medicines.
•The home had clean and tidy medicines rooms and medicines trolleys were used and locked when not in use.
•We observed registered nurses administer medicines with confidence and with sensitivity to people.

•Registered nurses only signed people's MARS when they were assured the person had received their prescribed medicines. A relative told us how thorough they thought staff were when managing medicines. They said, "Staff go through the medication" with people.

Systems and processes to safeguard people from the risk of abuse
•At the last inspection, we found the provider had failed to consistently refer certain incidents involving people to the local authority safeguarding team for their independent review when they occurred.
•At this inspection, we found staff had attended safeguarding training and told us they would go to a registered nurse, deputy or registered manager if they were concerned about people. However, this learning and approach was not consistently practised as staff had failed to identify the concerns we found.
•We found no incident report or investigation had been completed when people had gone for prolonged periods with no bowel movements. This meant no actions had been taken to prevent the risk of people experiencing further issues with their bowel and epilepsy management. We raised concerns with the local authority safeguarding team on behalf of a person who had not opened their bowels for three days and then suffered an epileptic seizure the following day.
•The provider failed to recognise incorrect mattress settings could place people at risk from skin damage. We referred a concern to the local authority safeguarding team where one person, who had a skin pressure wound at the time of the inspection, had an incorrect mattress setting.
•We have referred to the incidents reported earlier in this inspection report. It is the provider's responsibility to ensure their safeguarding systems protect all people using services from the risks of harm. Shortly after the inspection, the local authority safeguarding team informed us the concerns we had raised were considered to meet the threshold of section 42 safeguarding enquiries.

The above evidence shows that the provider failed to ensure systems and processes protected people from abuse and improper treatment. This was a continued breach of Regulation 13 of the Health and Social Care Act 2014.

•Some risks to people were being managed well. Five people required enteral feeding and had a percutaneous endoscopic gastrostomy (PEG) feeding tube fitted. A PEG allows nutrition, fluids and medicines to be put directly into the stomach, bypassing the mouth and throat. We observed registered nurses carrying out this aspect of care confidently, working in accordance with people's care plans and national guidance.
•We observed safe moving and handling practices were adopted throughout the inspection and staff supported people to move using the correct equipment, such as a hoist. The hoists we checked had been regularly maintained and were fit for purpose.

Preventing and controlling infection
•Staff had access to protective equipment such as gloves and aprons to use during personal care. During our inspection we saw that staff used these when supporting people, such as when doing baking activities or carrying out care.
•There was a daily and a weekly cleaning schedule and a housekeeping team who worked every day, including weekends.
•The service was clean and tidy and mostly free from any unpleasant odours. When we did highlight an odour in one person's bedroom the interim manager was quick to act to resolve the issue.

Staffing and recruitment
•Staff were only able to start employment once the provider had obtained suitable recruitment checks.
•This included; two satisfactory reference checks with previous employers and a current Disclosure and Barring Service (DBS) check. A DBS is a criminal records check. Staff record checks included validation of PIN

numbers for all qualified nursing staff. The pin number is a requirement which verifies a nurse's registration with the Nursing and Midwifery Council (NMC). This process ensured as far as possible, that staff had the skills and experience to meet people's needs.
•We observed there were enough staff working across each of the units to ensure people's safety. The provider told us they used a dependency tool to establish safe staffing levels.
• We were told and records confirmed, there were two registered nurses and enough care staff across each of the two units throughout the three days of the inspection.
•Agency staff were used almost daily. At the time of the inspection we were told the use of agency staff had increased due to permanent staff using up leave. The management team told us they tried wherever possible, to use agency staff people were familiar with and had worked at the home previously. We have discussed gaps in agency staff training in the Effective section of this inspection report.
•We saw that staff responded within a reasonable time to those who required assistance. In addition to care staff the provider employed an activities co-ordinator, maintenance, domestic and kitchen staff. This meant care staff could focus on providing care to people. One person told us, "They (staff) are pretty responsive, usually come within one – two minutes".
•One person told us, "I feel very safe". They told us they had originally started on short term care yet, "Liked it so much they decided to stay". They told us, "There seems to be enough staff". They added, "Staff are always attentive to me".
•A relative told us their family member was, "Definitely safe". The relative told us they preferred the provider using permanent staff rather than agency. However, they also said there was never all agency staff working without permanent staff to support them.

Inadequate

# Is the service effective?

## Our findings

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience
•The provider had its own training academy. They offered staff face to face and on-line training. At the last inspection, we found some staff had not attended specific training in relation to people's needs, such as acquired brain injury and Huntington's disease training.
•At this inspection we found permanent staff had been provided with opportunities to attend such training. However, improvements were still required with how the provider supported agency care staff they routinely used.
•For example, we spoke with one agency care staff member during the inspection. They told us they had worked at the home every couple of weeks for the past two years. We talked with them about their understanding of the people they supported. They told us they had read some of the care plans when they first started two years ago. They said, "When I first came here but not now". Care plans were reviewed monthly and within two years changes would have been made to care provided. The agency staff member had limited information to share with us about people's needs yet was aware some people had a learning disability.
•We checked the same member of staff's training record. This stated they had achieved six courses. This included health and safety and moving and handling. However, they had no previous training in the conditions experienced by people living at Horncastle Care Centre; including epilepsy or acquired brain injury. They had not attended any training in relation to the management of people who may display behaviours which may challenge.
•We checked nine other agency care staff training records and found similar gaps. The provider had not ensured all agency care staff had achieved training specific to people's needs and were competent prior to supporting people at Horncastle Care Centre. We fed this back to the management team for their review.
•The provider's training information stated 64% of permanent staff had attended training to manage behaviours which may challenge others. This can sometimes be called Positive Behavioural Support (PBS). The training can provide staff with a set of strategies to ensure they support people safely and effectively. However, our observations concluded that some staff did not know how to manage behaviours which challenged others due to the approach they used when supporting people. The regional operations director told us the provider's autism lead had started a training programme. However, at the time of this inspection improvements were needed to ensure all staff were given this opportunity. The provider also needed to ensure what staff had learnt was implemented effectively when staff were supporting people.
•We have raised concerns about staff training with the provider at the last inspection of Horncastle Care Centre and at inspections of some of the provider's other services. This had failed to drive sufficient improvements.

The above evidence showed that staff had not always received appropriate training to enable them to carry out their duties they are employed to perform. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Despite this staff told us they were supported well by the registered manager and other senior managers. New permanent staff attended an induction programme which included achieving the Care Certificate (Skills for care). This was a nationally recognised programme for staff new to health and social care. Other qualifications were encouraged such as health and social care diplomas. These are work based qualifications that are achieved through assessment and training.
•Staff attended regular staff meetings and were provided supervisions and appraisals and opportunities to be involved with the running of the home.
•One staff member said, "We work very well as a team with the manager". They added, "It's a fantastic place to work". Another staff member told us how the provider was supporting them to achieve their nursing qualification which they were very pleased about.

Ensuring consent to care and treatment in line with law and guidance
•The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 with appropriate legal authority. 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
•People did not always have capacity assessments in place. Where capacity assessments had been completed we found there were examples of multiple decisions being assessed at the same time. Mental capacity assessments should be decision specific to comply with the MCA.
•For example, one person's care record stated they had bed rails fitted for their own safety. There was a bed rails risk assessment in place but no separate mental capacity assessment and evidence a best interest decision had been made to ensure the least restrictive options had been considered. This meant the principles of the MCA had not been followed.
•No staff were aware whether any authorised DoLS had conditions that needed to be adhered to, this included the deputy manager. We checked authorised DoLS and found some conditions were not being met.
•For example, one person's DoLS was authorised in December 2018. One part of the conditions requested an urgent medicines review. We checked records and spoke with staff and found this had not taken place. We were told a GP visited every week so were concerned this had not taken place.
•There was an additional condition recommending decision specific mental capacity assessments to be made. However, we found 'blanket' mental capacity assessments and best interests decisions had been made on behalf of the person. This meant the requested changes had not taken place and the person's DoLS conditions were not being met. We found other similar examples which we shared with the management team for their immediate attention.
•Concerns about DoLS conditions had been raised with the provider at inspections of some of their other homes. Learning from this had not been effectively shared to improve staff knowledge or people's care at Horncastle Care Centre.

The provider had not ensured service users consent to care and treatment had been sought in accordance with legislation. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
•Most people living at the home needed a wheelchair for their mobility. Corridors and doorways were wide enough for people who used wheelchairs. At the last inspection, in April 2018, the provider was in breach of regulations associated with failing to adapt the environment for people. People who could manoeuvre themselves around their home in their own wheelchairs told us of their frustrations as they were unable to do so easily from their own bedrooms, without asking a staff member to help them. We shared the concerns with the provider at the time.
•After the inspection the provider wrote to us and told us they were going to, 'Make reasonable adjustments to the home to assist people to be able to move around independently e.g. explore switches to enable people to be able to operate doors opening/closing independently'. They told us they had met with the provider's estates manager in July 2018 where this was discussed.
•At this inspection we checked to see whether the provider had installed the new system. The management team told us quotes had been received yet no changes had been made. Whilst people did not share their frustrations at this inspection the same people lived at the home.
•Inspectors queried this with the management team. They told us that equipment for three switches had recently been ordered which would be fitted to three people's bedrooms. Reference to new switches being fitted was also made in meeting minutes since the last inspection. However, this meant at the time of this inspection, ten months later, the reasonable adjustments had yet to be made.

The above evidence shows that the provider was unable to demonstrate that they had made reasonable adjustments to the premises in accordance with the Equality Act 2010 and other current legislation and guidance. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•The provider was using nationally recognised, evidence based guidance, to track people's health care outcomes such as Waterlow charts. Waterlow is an assessment tool used to provide an estimated risk for the development of damage to a person's skin. However, this did not always lead to the effective management of people's skin integrity.
•The provider carried out assessments of people's physical health needs prior to them moving into Horncastle Care Centre. However, information was not always utilised in how risks were being managed, such as those with constipation or dehydration needs.
•The initial assessment process in place considered certain protected characteristics as defined under the Equality Act. For example, people's religion and disability. However, throughout this inspection we found examples whereby people's human rights were not consistently respected. For example, conditions in some people's DoLS were not being met.
Supporting people to live healthier lives, access healthcare services and support.
•Care records documented the input people received from healthcare professionals. This included chiropodist and neurologists. GP's visited the home weekly and any changes to people's health needs were discussed. A person told us the GP visited, "Every Thursday". They said they tell the registered nurse if they needed to see them and they were put on a list.
•People and their relatives confirmed they had access to health and medical professionals when they needed. One relative said, "Medically they respond and recognise if [named person] has a problem". They also said, "When [named person] has medical appointments, they call us if we want to attend but we don't have to as they're able to support [named person].

Supporting people to eat and drink enough to maintain a balanced diet
•Our findings of risks associated with the management of choking and hydration are referred to in the Safe section of our report.
•One person told us to food was, "Very good" and complimented the chef.
•A relative told us, "When I come at mealtimes I see everyone is getting attention". We observed mealtime support provided. Another relative said, "[Named person] has pureed food, it looks good and [named person] tells me its good. The nice thing is it's not all mixed up".
•Both Maple and Willow units have their own communal areas where people can eat their main meals. People that could communicate verbally told us they were happy with the food that was offered. One person told us they enjoyed eating by themselves as the dining areas were, "Too loud" and the staff team respected that. They said, "I eat at 12pm so the carers can put me to bed". They explained that they liked to rest in bed in the afternoon.
•Five people were supported by registered nurses to receive all their nutrition and fluid via a PEG. We observed this was carried out in accordance with care planning and PEG management guidance. They were also given the option of being in other areas of the home whilst people ate orally if they so wished, such as watching TV.
•Other people required varying levels of support. The chef was aware of any specialist diets and shared information with us they kept on file about the consistency of people's foods.
•Mostly staff presented as caring and attentive in their approach at mealtimes. We saw staff sitting at the same eye level as people they were supporting. They were observed smiling and talking with people about subjects they enjoyed, such as referring to their relatives and what they enjoyed watching on the TV. However, on the first day of the inspection we observed poor interactions between a registered nurse and the person they were supporting to eat their lunchtime meal. We have explored this further in the Caring section of this report.

Staff working with other agencies to provide consistent, effective, timely care
•There were examples of how the provider had sought advice from external agencies to ensure people's needs were being met. For example, the provider's physiotherapist told us they had contacted the local authority's occupational therapy team when they needed advice on a new hoist. The new hoist was being used at the time of this inspection.
•The home carried out handovers between the day shift and night time shifts. This was a discussion about how people they supported had presented throughout the day. A summary regarding the main needs of a person was also available in written form in a handover record. This helped inform all staff including agency staff who may not be as familiar with a person's needs.

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

People were not consistently treated using caring approaches, as their dignity and privacy was not always respected.

Respecting and promoting people's privacy, dignity and independence
•At the last inspection we observed kind and caring practices from all staff supporting people. At this inspection our observations were mixed. Some staff were attentive towards people and engaged positively with them. However, we also observed disrespectful practices which other staff failed to challenge at the time.
•For example, some staff did not knock on people's bedroom doors and wait for a response before entering. It is important staff show people respect when entering people's bedroom as it is their personal space and privacy should be respected. People with neurological conditions and learning disabilities may need time to provide a response. People should be given a choice on whether they want support at that moment as it may not be convenient for them.
•A registered nurse was showing us around the home and introducing us to people. They knocked on a person's bedroom door yet did not wait for a response from them before entering their bedroom. The person was involved in personal care. They said, "Can you give me five minutes?" The registered nurse then walked out and closed the door. By entering the person's bedroom without waiting for a response first meant the registered nurse had failed to promote the person's dignity and respect their privacy.

Ensuring people are well treated and supported; equality and diversity
•Most staff supported people with meals sensitively and competently. However, we observed one occasion where this was not the case. One person had physical disabilities and could communicate verbally. They talked to us about some aspects of care they were not happy with. They said, "Nobody listens to me". We observed the same registered nurse supporting them to eat. They failed to engage with them whilst supporting them and did not tell them when food was coming towards their mouth. There were no positive interactions from the registered nurse. At one point the person said to them, "Can you slow down please?" But we observed the staff member continuing at the same pace and not respecting their wishes. The registered nurse also supported them with their drink, yet failed to offer it to them until after all their meal was finished.
•The approach used was more concerning as it was a registered nurse who care staff and agency care staff told us they look to for guidance. We have spoken to the provider about ensuring caring approaches are practised consistently and challenged accordingly when failings are identified.

Supporting people to express their views and be involved in making decisions about their care
•People were not always encouraged to express their views. For example, we were being shown around the building on the first day of the inspection. A person started talking with us and we engaged in conversation. They were interested in who we were and what we were doing in their home. However, a staff member

interrupted them and spoke over them disregarding their interest in what the inspectors were doing and started introducing us to another service user.
•We also found the provider in breach of regulations associated with how risks were being managed on behalf of people and how people were not always protected from the risk of harm, this was not reflective of a caring culture.

The above evidence showed the provider was failing to ensure and people's dignity and right to privacy were consistently respected which was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Despite this, our other observations of staff were positive. This included staff responding to people's requests in a timely manner and supporting people with choices about where they wanted to spend their time.
•For example, one staff member had a kind and caring manner and involved a person in all aspects of care provided. They said, "Do you want to hold the cup", when supporting them to drink. The staff member sat near them when they were drinking but allowed the person to do it for themselves which promoted their independence.
•People and their relatives told us they found staff and the registered manager used caring approaches and felt involved with their own care.
•One person told us staff were, "Very caring" and "Very friendly". They added, "They let me get on with everything" and explained staff encouraged them to be independent.
•One relative said, "It's the best place [named person] has ever lived". They added, "Their needs are well met". They also said their family member was, "Treated very fairly".
•People and their relatives told us that they appreciated visitors were encouraged and welcomed to the home. One relative said, "Our children visit with their grandchildren and they're very welcome".
•People were provided with annual care reviews. This was an opportunity to discuss all aspects of their care received. There were also meetings within the home to discuss people's likes and dislikes with regards to activities they attended. We noted the minutes to these were all in the written form which may not have been accessible to all people. This meant some people would not have been as involved with their own care as was possible. We have discussed this further in the Responsive section of this report.

Requires Improvement

# Is the service responsive?

## Our findings

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

People's needs were not always met. Regulations were not met.

Planning personalised care to meet people's needs, preferences, and interests, choice and control.
•We found activities and occupation were being offered and provided to people. However, improvements were needed to ensure they met all people's individual needs. We observed some people attended group activities which met some people's needs but not all.
•For example, on the first morning of the inspection we observed a music session which took place on the Willow Lodge. There were 13 people out of 19 in a communal lounge. An external music entertainer facilitated the session and three staff were available in the room to support people. Instruments were given out to some people. However, others sat and watched or were unable to hold what was being offered due to their physical disability. We observed two people particularly enjoying the session, staff engaged with them and supported them to choose instruments and song's they liked. However, the same attention was not given to all people sat in the room by staff. Considering this was the main activity for the morning not all people would have benefitted from this activity as they could not be fully involved.
•People's preferences with regards to how they wanted to spend their day were captured within care plans. Staff completed activity monitoring charts to state what a person had achieved each day. However, we found improvements were needed to ensure opportunities to enhance a person's day were considered for all people, not just some.
•For example, one person had an acquired brain injury and required support from staff for all aspects of their care. Activity plans highlighted the importance of staff encouraging the person with their, 'hobbies and interests' which included staff talking with them as this is what they preferred. In February 2019 the person had visited a garden centre twice and been shopping to the local town; which matched their interests in their care plan. However, during the inspection we often observed they were sat alone without staff support. For example, we observed a period for 40 minutes where the person was sat to the side of the TV not watching or engaged with what was on the TV. Staff did not talk to them during this time. In between trips out activity charts often stated, 'watched TV'. This meant there were often occasions in between trips out where the person was not involved in meaningful activities which they preferred.
•On the third day of the inspection we observed the same person watching a group activity of making pancakes. They were sat with another person who also watched but was not encouraged by staff to participate. Staff were supporting a person who was physically able to achieve making the pancakes. Although this activity was a positive experience for the person engaged with it, it also was a missed opportunity for others watching who were not actively engaged and involved with what was going on.
•Two people living at the home were described as having behaviours which may challenge others. At the time of this inspection improvements were required to support staff to manage this safely. Whilst the provider's autism lead had commenced work to support one person, we found improvements were needed to ensure both individuals had increased activity opportunities which met their needs.
•For example, one person received one to one support. They had a DoLS condition which discussed the types of activities and the frequency they needed to be offered to them. Their care record discussed they

may decline activities. However, there was no guidance for staff on how to manage this, such as whether an alternative should be offered to ensure opportunities to leave the home were provided.
•Activity records for December 2018 and January 2019 showed there was a period of 21 days where they did not leave the home. Records failed to demonstrate what activities had been offered and if declined what alternatives were offered to the person. The staff team told us this was because they declined activities but they were now in the process of organising more activities the person enjoyed. At the time of this inspection improvements were required to ensure their one to one staff was fully utilised and the DoLS condition met. We discussed the provider's failings to meet some people's DoLS conditions earlier in this report.
•Another person, who was diagnosed with a learning disability, displayed behaviours which challenged others. We observed there was limited positive interaction from staff with the person. We checked their activity records. They visited their relative regularly at weekends. However, their activity records demonstrated they had limited opportunities to access the wider community with staff during the week. For example, in January 2019 they left the home for a medical appointment only.
•The principles of registering the right support were not upheld consistently on behalf of people with a learning disability. People were unable to access some activities, were unable to fully be part of the community, and were not supported in a person-centred way.
•The provider mostly used a written format for care plans and meeting minutes which was appropriate for some of the people living at the home but not all. The Accessible Information Standard (AIS) is a requirement of NHS and adult social care services to ensure that people with a disability or sensory loss are given information in a way they can understand. Whilst care plans referred to the AIS, there was a lack of assessment completed to show how information should be recorded or shared with the person in an accessible way that specifically met their communication needs. Some people had relatives that could support them with this, however this failed to promote a person's independence.
•For example, people were offered meetings to discuss activities they preferred. However, the minutes were recorded in a written format which meant some people would not have been able to understand them. The provider had not considered what may be a reasonable adjustment to assist some of the people they supported in accordance with their needs and abilities.

The failure to provide centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Despite our observations people and relatives told us they received personalised care and they enjoyed the activities offered. One relative provided an example of where their family member wanted their hair dyed and they were supported to make this choice and where they had it done.
•Another person was particularly pleased as they could maintain their independence and spend their day as they wished. They enjoyed going out on a one to one with staff rather than in a group and told us the staff team respected that. They told us they enjoyed gardening and said, "I just love being outside".
•People and their relatives spoke affectionately about seasonal parties such as the summer BBQ and Christmas festivities which they told us they enjoyed. They said their family member, "Has a great social life: theatre, meals, pubs, shows, [named person] gets good attention".
•We found the staff team had responded to people's preferences with regards to how bedrooms were decorated. Bedrooms reflected the age, style and interests of the person. People could display all their personal items, such as posters of their favourite popular music artists and had choice over the colour of paint used on the walls. A relative told us, "Families are encouraged to personalise bedrooms".
•□Photographs of people were used in their moving and handling guidance. This meant staff had access to both written and visual formats to support and respond to people's moving and handling needs.

Improving care quality in response to complaints or concerns
•Complaints made by people and their relatives were considered and responded to. There was a complaints

policy in an accessible format, in place available for both people living at the home and their relatives. There was a log of all complaints and the actions taken by the management team. There were no formal complaints open at the time of our inspection.
•People and their relatives told us they would take any complaints to the registered nurses, deputy or registered manager. We received positive feedback about how complaints were managed. One person said, "If you bring a complaint or a niggle its done and sorted as soon as you mention to [named registered manager]".

End of life care and support
•At the time of this inspection, there were no people receiving end of life care. However, procedures were in place with the GP so that people would be supported to be as comfortable, dignified and pain free as possible at the end of their life.
•People and their relatives had been consulted about their wishes in the event of their death and this was recorded in their care plan.

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.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Continuous learning and improving care
•At the inspection in April 2018 we found the provider was in breach of five Regulations.
•At this inspection, we found improvements had not been made by the provider and the quality and safety of care provided had significantly deteriorated. All five breaches from the last inspection continues at this inspection and we also found additional breaches of regulation as people's privacy and dignity and the need for person-centred care was not consistently respected. Areas of concern highlighted at this inspection included epilepsy, constipation, hydration and behaviour management, choking risks, operation of MCA and DoLS and agency staff training. All of these issues have been highlighted as themes to the provider at inspections of some of their other services. Despite this, learning from CQC inspections had not been shared effectively or used to improve the standards of safety and quality at Horncastle Care Centre.
•The provider used systems to check the quality and safety of care provided. However, these continued to be ineffective. They did not always identify concerns and drive the necessary improvements needed to ensure safe and high-quality care was delivered to people. This included making improvements to the concerns we found at the last inspection.
•For example, since the last inspection, monthly visits by the provider's regional operations director or peripatetic managers had been carried out to make checks on the care provided. These checks had failed to identify risks to people's safety and well-being and to bring about mitigating actions. The provider also had their own quality assurance team who last audited the home in December 2018. The team had devised a 'service improvement plan' with a list of 15 points which needed addressing. The document stated 'continue the process of reassessing people's risk assessments' and mentions bowel and fluid charts. However, we continued to find that risks associated with constipation and hydration had not been properly assessed or reduced in practice.
•The provider told us they had identified improvements were needed in how the staff supported a person who displayed behaviours which may challenge others. However, at the time of this inspection staff were responding negatively towards the person and lacked awareness of how to support them appropriately.
•Not all aspects of care were checked by staff including registered nurses or managers. This included failings in checking specialist mattresses were set incorrectly and checking whether all people received the recommended amounts of fluid. We found some mattresses were set incorrectly and placed people at risk of pressure skin damage. The provider also failed to identify one person had not received the recommended amount of fluids as they had not checked this aspect of care.
•There was a lack of oversight and checks made into whether all people were accessing the community enough. Because of this the provider had not identified one person was not accessing the local community in accordance with their needs and their DoLS conditions. We have referred to this in the Responsive section of this report.

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

•Leadership of the service was not always effective. The provider and registered manager had failed to ensure that people's needs were known and met. This had an impact on people's safety, and the quality of care they received.

•The provider's quality audit also discussed the importance of consent. Yet it failed to identify all legal requirements were being met and the staff team were following the principles of the MCA 2005 and DoLS legislation. At the time of this inspection staff were not aware of their responsibilities in accordance with meeting conditions in people's DoLS and therefore there were legal requirements not being met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

•The provider had made improvements since the last inspection to training attended by its permanent staff. The audit in December 2018 checked staff training. Yet it failed to highlight some agency care staff had not attended specific training in relation to people's conditions and diagnoses.

•Whilst we accept agency care staff worked alongside permanent staff, it is the provider's responsibility to ensure all staff supporting people had a basic awareness of why a person presented as they did. This is to ensure personalised, effective caring approaches are used when staff are supporting people. We have discussed gaps in agency care staff training with the provider since July 2017.

•The management team kept the day to day culture under review and was an active presence in the home. However, there were some issues we found with the culture in the staff team such as people being spoken to in an undignified manner, and people's dignity not being consistently promoted. Our observations were that this was not challenged by other staff which would have led to better, more positive outcomes for people living at the home.

The above evidence shows that the systems or processes in place were not consistently effective. There was a failure to assess and monitor and to improve the quality and safety of the services provided. There was a failure to maintain an accurate and cotemporaneous record in respect of each service user. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Despite this we received positive comments from some people and their relatives about the support the registered manager had provided them. We were unable to speak with the registered manager and the interim manager supported the inspection. One person told us the registered manager was, "Lovely been here for years and [named registered manager] always listens". They said Horncastle Care Centre was a, "Home from home". Another person said the manager did a, "Good job, works hard".

•We found some systems working well at the home. This included the National Early Warning Score (NEWS) we sampled. This is a clinical assessment tool. NEWS determines the degree of illness of a person using physiological findings and observation. We found the NEWS was being completed as intended and was used as a method of assessment when a person became unwell.

•Audits were being completed to evidence that checks around cleanliness were being completed and the risk of infection was being managed.

•The management team, including the interim manager and the regional operations director involved in the inspection were approachable and helpful to the inspection team. A relative told us they appreciated the approach the registered manager used and said, "I have a good working relationship with [named manager]".

•The interim manager had only started working at the home to support the staff team, the day before the inspection. Therefore, they were new to people and the staff team. They were aware of the duty of candour.

The duty of candour is a duty to be open and honest with people, or their families, when something goes wrong. They agreed with our findings associated with risk management and started to implement necessary changes to improve care provided to people.

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

•People and their representatives such as relatives attended annual care reviews. This was an opportunity to discuss what was working well and what areas of care required further support and action. Other health and social care professionals such as social workers or GPs could attend if required. A relative spoke about such reviews, said they appreciated being involved with their family member's care and was pleased the registered manager's, "Door was always open".

•The provider sent surveys asking people and their relatives views on the care provided. People were given pictorial surveys to complete. The completed responses we read were positive.

•Staff were involved in the running of the service. Staff meetings were announced in advance and the agenda was discussed. The registered manager prepared the agenda in advance and gave staff an opportunity to say if they had any concerns or make contributions to the meeting. A staff member told us it was a, "Fantastic place to work".

Working in partnership with others

•Some people were involved in arts and crafts at the home. We were told staff were going to approach a local library to see if people's art work could be exhibited.

•A relative told us their family member attended church every Sunday and we were told the local church also visited and spent time with people.

• The CQC's rating of the home, awarded at the last inspection, was on display at the home and on the provider's website.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Person centred care was not consistently provided |

**The enforcement action we took:**

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>Service users privacy and dignity was not consistently respected |

**The enforcement action we took:**

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider failed to work in accordance with MCA 2005 and DoLS legislation. |

**The enforcement action we took:**

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>All was not done reasonably practicably to |

mitigate risks on behalf of service users

**The enforcement action we took:**

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

| 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<br><br>Service users were not always protected from abuse |

**The enforcement action we took:**

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>Failure to make reasonable adjustments to premises in accordance with the Equality Act 2010 |

**The enforcement action we took:**

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had ineffective governance systems to check the quality and safety of care provided to service users |

**The enforcement action we took:**

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 18 HSCA RA Regulations 2014 Staffing |

| | |
|---|---|
| personal care | Failure to ensure all staff received appropriate training to enable them to carry out their role |

**The enforcement action we took:**

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location in July 2019. The enforcement action took effect in June 2020. Horncastle Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.