Sunrise Care Homes Limited

The Mount Residential Home

Inspection report

The Mount, Heydon Road
Aylsham
Norwich
Norfolk
NR11 6QT

Tel: 01263734516

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Mount is a residential care home providing personal and nursing care to 17 men. There were younger people and people aged over 65 with mental health care and support needs. Some people were living with dementia. The service can support up to 22 people and accommodation is provided over two floors.

People's experience of using this service and what we found
The quality of care provided at The Mount Care Home was poor. People were not being protected from risks of abuse and harm, due to the poor condition and cleanliness of the care environment and a lack of risk management and oversight in place by the provider. People were not supported to lead meaningful lives or be part of their local community. People's privacy and dignity was not being protected, and people were not receiving individualised, person-centred care.

Staff did not have the required skills, training, and knowledge to support people living with complex mental and physical health care and support needs. This resulted in poor monitoring and a lack of risk assessments in place, including for those people assessed to be at risk of choking, falls and requiring support with their medicines.

There were a number of health and safety concerns identified, including in relation to smoking and fire risks, water safety and ligature risks. The lack of provider level audits in place, did not ensure people were being kept safe, as risks were either not recognised or not being addressed. Staff were not following the provider's own policies, and the lack of supervision and oversight of staff performance by the registered provider did not ensure shortfalls were being addressed, resulting in people being exposed to harm.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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

Rating at last inspection and update The last rating for this service was good. (Published 12 July 2019).

Why we inspected
The inspection was prompted in part due to concerns received following a recent quality monitoring visit completed by the local authority quality assurance team, which identified a number of concerns relating to safe care and treatment at the service. A decision was made for us to inspect and examine those risks.

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

You can see what action we have asked the provider to take at the end of this full report.

We have found evidence during this inspection that people were at risk of harm, the provider needs to make improvements. Please see all sections of this full report for further details.

Enforcement and Recommendations
We have identified breaches in relation to protecting people's privacy and dignity, providing person-centred care and support, safe care and treatment including infection, prevention and control and medicines management, safeguarding people from risk of harm and abuse, safe support with eating and drinking, good governance and oversight of the service, sufficient numbers of suitably trained staff to meet people's assessed needs and risks, safe recruitment processes, at this inspection.

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

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

Follow up
We will 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 placed in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Mount Residential 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
On the first day of inspection there was 1 inspector. For the 2 other days of inspection there were 2 CQC inspectors.

Service and service type
The Mount 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. The Mount is a care home without 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 not a registered manager in post, and there had been with a lack of managerial oversight since June 2022.

Notice of inspection
Each day of inspection was unannounced, and included an out of hours inspection visit.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

In the absence of a registered manager, we sourced information and assurances from the nominated individual who is also the registered provider. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

During the inspection
We spoke with the provider and interim deputy manager, independent consultants, members of the care, kitchen and housekeeping team. We reviewed 7 people's care records in detail and 9 people's medicine administration records. We looked at staff files in relation to recruitment and staff supervision. We reviewed a variety of records relating to the management of the service, including policies and procedures. We spoke with a number of people who used the service. We liaised with the local authority safeguarding team, fire and rescue service, quality assurance team and GP surgery. After our inspection visits, we continued to seek clarification from the provider to validate evidence found. We gave written inspection feedback after each site visit.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- From reviewing the provider's accident and incident records, we identified a number of incidents, including where people had sustained unexplained injuries, which had not been reported to the local authority safeguarding team or to CQC.
- Due to the poor quality of care records and a lack of auditing in place, we identified examples of incidents which had happened, but were not reflected on the provider's own incident log. There were no assurances provided to demonstrate appropriate action, such as sourcing medical input, was taken to protect people from harm following incidents.
- Safeguarding referrals were made to the local authority as an outcome of inspection findings on days 1 and 2 of inspection, as we were concerned for the safety and welfare of people living at the service.
- The condition of the care environment and poor risk mitigation did not protect people from risk of harm or abuse. There was evidence of a closed culture within the service, with a lack of transparency, poor engagement and oversight from the provider to protect people from harm.

The care provider was not identifying or reporting safeguarding concerns to protect people from the risk of harm and abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- There was poor awareness and management of risks. We identified a lack of risk assessments in place relating to management of those people at known risk of choking.
- There was a lack of recognition of risk mitigation relating to those people living with mental health care and support needs, including people who experienced self-harming behaviours that placed themselves or others at risk.
- Oversight of people who experienced falls was poor. Staff were not monitoring people following a fall to ensure they had not sustained head injuries. There was a lack of management plans in place to mitigate risk of further falls, and staff were not ensuring timely medical assistance was sourced where people had sustained injuries.
- Use of the stairs and people at increased risk of falls had not been considered; the people carrying lift had been out of order for a number of months prior to our inspection.
- Fire safety and risk management was poor. People were known to smoke in their bedrooms, but no additional safety measures had been implemented. An independent fire risk assessment was completed during our inspection, which identified a number of risks and concerns requiring urgent, immediate attention. The service had not had an independent fire risk assessment completed since 2015.

● Not all bedrooms had access to running water in their wash hand basins, or where they did, this was not always found to be warm. This did not support people to maintain their personal hygiene and presentation and increased the risk of the spread of infection. We identified unprotected hot surfaces such as radiator pipes, increasing the risk of burns and scalds throughout the service.

Risks relating to the health and welfare of people were not 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.

Staffing and recruitment
● We reviewed staff files and identified gaps in the recruitment process to ensure staff had the required skills and experience to meet people's needs safely.
● Many staff were employed through the government sponsorship scheme. The provider was not clear the maximum number of hours staff should legally work, and any limitations for example linked to their visas. We also felt staff were not confident to raise concerns about the service or care provided as this placed their sponsorship status at risk.
● We identified some staff members were living on the premises, including a family with a child. These arrangements had been poorly risk assessed by the provider to protect the welfare of those staff, but also the people living at the service. Whilst not part of our regulatory responsibility, the conditions of the staff living quarters were poor.

Risks relating to the fitness and safety of staff employed at the service remained an area of concern. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People were not being supported to take their medicines in a person-centred way. Where people were refusing to take their medicines, or inappropriately disposing of them, staff were not assessing the associated risks or escalating this information to the GP. This resulted in poor health outcomes for people.
● The service did not complete their own audits of the medicines in place each month. This did not ensure any errors were being identified and addressed. An independent consultant completed a medicines audit at the start of April 2023, which identified a number of risks and concerns the provider and staff had not previously recognised.
● Arrangements were not in place to ensure medicines were being regularly returned to the pharmacy for safe disposal, resulting in large quantities of medicine being in the medicine room.
● Staff were not following the provider's own medicine management policy. For example, where people required tablets to be cut in half. The remaining half was not being disposed of in line with the policy, impacting on the efficacy of the remaining medicines being given to people.
● Guidance in place for staff to follow where people needed as required (PRN) medicines was poor quality and lacked guidance to ensure alternatives to medicine had been considered first. People's homely medicine plans were not being regularly reviewed or updated.

Risks relating to the management of people's medicines and the associated risks were identified. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
The care environment was visibly dirty, smelt strongly of malodours throughout, and was in a poor state of

disrepair impacting on the ability of staff to keep the environment clean. There was a lack of spot checks and monitoring by the provider to ensure cleaning tasks were completed to a good standard.
● We were not assured that the provider was preventing visitors from catching and spreading infections.
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were not assured that the provider was admitting people safely to the service.
● We were not assured that the provider was using PPE effectively and safely.
● We were not assured that the provider was responding effectively to risks and signs of infection.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were not 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, but not being implemented into staff practice.

Procedures were not in place to prevent the risk of the spread of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● Visiting arrangements were in place at the service, however, there was a lack of up-to-date guidance and risk management arrangements to maintain visitor's safety.

Learning lessons when things go wrong
● The outcomes of each inspection visit resulted in written requests being made to the registered provider to make urgent improvements to the service. Timely responses to our requests did not result in improvements being made to reflect learning from feedback and implementation of change.
● The local authority quality assurance team completed a monitoring visit in February 2023, which identified a number of risks and concerns the provider needed to address resulting on an embargo on placements being implemented. The provider had not acted on the feedback received and risks remained present when we inspected a month later.
● Poor engagement with external stakeholders, and repeatedly not acting on feedback received resulted in a deterioration in rating and breaches of the regulations. The provider has missed opportunities to learn, reflect and address risks before reaching this level of concern.

Inadequate

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

- From reviewing staff rotas there was only two staff on shift at night time. The service had not completed any fire drills to determine the number of staff required, including at night, to support people in the event of an emergency, such as needing to evacuate the service.
- Oversight of staff performance was poor. The provider was unable to provide evidence of staff having supervision prior to March 2023. The provider confirmed no staff had received performance appraisals. This did not demonstrate investment in staff development.
- The service's own training matrix identified gaps in training and a lack of checks in place of staff competency, and implementation of training into practice.
- There was poor monitoring in place by the provider and senior members of staff to ensure new staff were given the opportunity to familiarise themselves with people's needs prior to working alone.

Sufficient levels of suitably trained competent staff were not in place to keep people safe. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Staff lacked training, competence and managerial oversight to support people to eat and drink safely. We witnessed a person choke on their meal, and action to source an urgent medical review from the GP was only made at our request.
- There was a lack of guidance in place to ensure staff were supporting those people requiring use of drink thickener and food of specific consistencies to ensure they maintained good daily food and fluid intakes.
- People were being regularly weighed, but a recognised assessment tool was not being used to monitor for changes in weight and identify when a referral to a dietician or the GP was needed.
- The quality of food provided was basic, with many meals we observed consisting of mainly frozen, pre-prepared items. Choice was limited and portion sizes did not vary to allow for individual preferences.
- The dining experience was poor. People were not all given their meals at the same times, so some people had finished and were asking for their deserts while other people had not started their meals. People did not have access to condiments.
- We observed mealtimes where people asked for a second portion of lunch, staff confirmed this would be possible, but it was not then provided. We observed people sitting for over 40-minutes waiting to be given a hot drink and their breakfast, including where people were calling out, they were hungry, or going to the kitchen to request their breakfast directly.

The care provided did not ensure staff had the skills and training required to support people to eat and drink safely. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The consideration and assessment of people's capacity was limited, and those assessments in place were not decision specific in line with the MCA.
- People's care records and conversations with the provider demonstrated a lack of understanding regarding the difference between assessing a person's mental capacity and assessing their mental health, and the different actions and options needing to be considered as a result.
- The provider was unable to tell us if people with a DoLS in place had conditions attached that staff needed to follow and did not attempt to refer to any relevant documentation. We liaised with the local authority and confirmed some people's authorised DoLS did have conditions attached.
- Inspection findings highlighted people's equality, diversity and human rights were not being upheld.

Staff were not always working in line with principles of the MCA legal framework. This was a breach of regulation 11. (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's choices and involvement within the running of the service was limited. Staff were offering people limited choice and control in relation to their daily routines, dietary wishes and preferences, and were not providing one to one activities and social contact to reduce the risk of isolation.
- Records did not demonstrate people and their relatives were consulted in relation to the care and support provided. Each person's care records contained limited detail and were not consistently being reviewed each month or updated following incidents and accidents.
- Nationally recognised clinical assessment tools and approaches were not being used by the staff, in line with recognised best practice. Additional training was required to support staff to be confident in their roles.
- We observed individual staff member's approach to supporting people to vary. Some were not guided by the person's wishes and preferences and did not ensure that people maintained control of their care and decision making. For example, we observed a staff member giving a person food against their wishes, and not stopping when the person was repeatedly pushing their hand away.

● Staff had not completed oral hygiene training, to ensure they offered people the right level of support and knew when to request involvement from a dentist. This did not demonstrate the provider was ensuring staff worked in line with oral care guidance from the National Institute for Health and Care Excellence.

Adapting service, design, decoration to meet people's needs
● The service was poorly decorated throughout. People's bedrooms were not personalised, and many were bare.
● Bedding and seating in people's rooms was in poor condition throughout, with some bedding and seat cushions containing visible holes and tears. Bedding did not match and was often heavily stained and marked.
● There was limited signage throughout the service to support people to orientate to their environment, particularly those living with dementia.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Prior to our inspection, the local authority had shared concerns with us, from the GP practice. This identified poor engagement with the service, concerns regarding people having unexplained bruising and staff not taking people's urine samples to the surgery to be tested for possible infections.
● People were not encouraged to lead active lives, and did not have access to healthy meal options, or fruit and snacks between meals, unless this was something they or a relative brought into the service.
● Inspection findings identified a lack of timely referrals being made where people required a GP review, particularly in relation to the management of people's medicines, or changes in their swallowing abilities.
● Staff demonstrated a lack of awareness of who they should approach to seek advice, for example in relation to queries regarding medicines management, or if a person required a review of the suitability of their placement at the service.
● We experienced a lack of engagement with the inspection process by the provider. The provider arranged for an independent consultant to start supporting the service but did not complete any due diligence checks of their experience and suitability to support the level of change required at the service.
● Overall, the standards of care provided and a lack of collaborative working with other professionals was poor, and did not ensure safe, positive outcomes for people.

Inadequate

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence
- People's privacy and dignity were not upheld. We identified bedrooms where curtains did not meet in the middle, and staff were providing personal care to people who could be clearly seen from outside.
- Where people shared a bedroom, there was no method of dividing the room to provide privacy while completing personal care tasks including using a commode.
- Where people were experiencing difficulties managing their continence needs, suitable management plans were not in place to protect their dignity, resulting in people living in an unclean environment, with the presence of malodour.
- Staff did not recognise the need to ensure people were supported to maintain cleanliness and personal presentation. For example, we observed a person supported by staff to mobilise into the dining room, and eat their dinner having been incontinent, but the staff did not offer to assist the person to change their clothing until after then had eaten.

The care provider was not ensuring people's standards of dignity and respect were being protected and upheld. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
- The care people received lacked choice and options to ensure people's wishes and preferences were maintained.
- Care records, and approaches taken to deliver care were generic and did not respect people's individuality, or protected characteristics such as disability or sexuality. Staff had not been given access to any additional training to support this part of their role.
- Staff were found and observed to mainly be caring, but their abilities to provide person-centred care was being compromised by a lack of role specific training and oversight from the provider to ensure basic standards of care were being met.

Supporting people to express their views and be involved in making decisions about their care
- The provider was unable to provide evidence to demonstrate meaningful meetings were held with people to ensure feedback on the running of the service was sourced either in group or on a 1:1 basis.
- People's care records did not reflect their involvement in the design and relevant decision making, or collaborative working with relatives.
- People were not supported to set short-term or longer-term goals, for example to develop independent

living skills or focus on the option of moving on from a residential setting to living in their own home.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- Care was not tailored to people's individual needs, and preferences. There was a lack of flexibility in the daily routine to offer people choice and control over their lives.
- Care records did not contain evidence of people and their relatives, where appropriate, being consistently involved in decision making relating to their care and support needs and wishes. There was also a lack of information for those people no longer able to express their wishes verbally to staff to ensure their past wishes were upheld.
- Care records did not contain detailed guidance for staff, for example, in ways to support staff with understanding people's methods of communicating their thoughts and feelings. Where people were living with mental health care needs, there was a lack of crisis support planning in place to ensure their wishes were maintained when unwell.
- Use of poorly trained staff posed a risk for those people with limited abilities to communicate to ensure their needs were recognised and met.

The provider was not ensuring people received personalised care, tailored to their individual wishes, 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.

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

- Staffing levels, knowledge and understanding of people's mental and physical health and support needs was poor. This impacted on people's levels of community activity. If people required support to access the community, then staffing numbers would need to have been reviewed to ensure those people remaining at home could also be kept safe.
- From our three inspection visits, we did not observe any meaningful individual or group-based activities in progress. There was a lack of structure and people were not supported to maintain or develop new hobbies and interests.
- Efforts had not been made to form connections with the local community, or support people wishing to engage with external activities or employment opportunities.

Improving care quality in response to complaints or concerns

● We identified a serious incident which happened at the service, born out of a complaint. This had been poorly handled by the provider, with a lack of information sharing with relevant health and social care professionals. The poor handling of the complaint did not ensure a collaborative approach to identify subsequent action was taken to reduce the risk of reoccurrence.

● The provider was not actively sourcing feedback from people living at the service, however, information on making complaints was displayed in the service.

End of life care and support

● There was no one receiving end of life care at the time of our inspection.

● The provider's training matrix did not demonstrate that staff received training in the provision of end of life care, or in relation to supporting people to have discussions and make plans for their future care needs to ensure their wishes and preferences were known.

● There was a poor level of end of life care planning present in people's care records.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The condition and cleanliness of the service did not ensure good care outcomes for people. Staff lacked the required training and expertise to recognise people's individual support needs and risks, resulting in care, which was not safe, individualised or person-centred.
- We identified evidence of a closed culture within the service. We identified examples of accidents, incidents and a complaint which had not been openly shared by the provider with external professionals and stakeholders.
- People were not empowered, and overall the care and living environment was found to be institutionalised and outdated in approach.
- The provider demonstrated a lack of value placed on their staff team. There was a lack of investment and support to ensure staff flourished, particularly those new to social care.
- Whilst we are not responsible for regulating staff accommodation, staff quarters were in a poor condition and the provider did not implement robust risk assessments to keep staff, their family members or people living at the service safe.

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

- The provided demonstrated a clear lack of recognition of their own regulatory responsibilities and accountability, including where things went wrong. The provider demonstrated a lack of engagement with the inspection process, and an unwillingness to be open and honest with inspectors.
- The provider demonstrated a lack of knowledge of people's individual risks and support needs, to ensure they provided a service that was safe and fit for purpose.

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

- Where enforcement action was taken by CQC as an outcome of each inspection visit to the service, the provider demonstrated a lack of recognition of the need to take timely, robust action and provide assurances to address the seriousness of our concerns and findings.
- The provider's statement of purpose contained inaccuracies, including details of the wrong regulated activity being provided and out of date management details. (A statement of purpose is a legally required document that includes a standard set of information about a provider's service).
- In the absence of a registered manager, the provider had been responsible for overseeing the running of

the service since June 2022. The deterioration in rating and breaches of regulation demonstrated a clear lack of understanding of their own regulatory responsibilities.

● The provider did not recognise their individual regulatory responsibility to ensure they notified CQC of incidents and accidents at the service. They had failed to notify CQC of their people carrying lift being out of operation for over 2 months. Where people had sustained unexplained injuries or bruising, the provider failed to notify CQC or the local authority safeguarding team.

● Where audits were being completed, these were of poor quality, and did not identify where action needed to be taken, therefore did not drive safety and improvement at the service. Findings in audits did not reflect the risks and concerns found during our inspection.

● Provider level oversight of the service and staff performance was poor. They had not identified staff were not adhering to their own policies and procedures. Where CQC brought concerns to the attention of the provider, they demonstrated a lack lustre approach to addressing them.

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

● Where feedback from people's relatives had been sourced, this was poorly analysed, and did not evidence action taken in response to feedback.

● People's care records were generic, and did not contain key information or contained inaccuracies, impacting on the information available for staff to follow. Due to a lack of care record audits being in place, the provider was not identifying shortfalls and ensuring records were accurate and person-centred.

Continuous learning and improving care

● Since registering the service in 2010, there had been four previous inspections, and the provider had only once achieved a rating of compliance with the regulations. This inspection was completed following a quality monitoring visit by the local authority, and the provider did not act on their feedback to drive improvements at the service.

● Where accidents and incidents had happened at the service, there was no trend or thematic analysis being completed by the provider to learn from these events and to implement changes to reduce the risk of reoccurrence.

Working in partnership with others

● The care provided demonstrated a lack of joint working with external health and social care professionals, as well as with people living at the service and their relatives. This resulted in poor care outcomes and missed opportunities to improve care standards.

● Where external professionals provided feedback to the provider, this was not acted on to address risks even where these were identified as needing urgent or immediate attention.

● The provider was not sourcing timely external contractors and maintenance works to address the condition of the service. Where actions were identified, there was a lack of clear timeframes for improvements agreed with external contractors to be made to the condition of the environment to improve people's quality of life.

The provider had poor governance and oversight arrangements in place to maintain standards and drive improvement at the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care provider was not providing person-centred, meaningful care. People were not supported in line with their own wishes and preferences. This was a breach of regulation 9 (1)

The enforcement action we took:

Cancellation of the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The care provider was not upholding people's privacy, dignity and human rights. People were not protected from harm, or treated respectfully and with consideration. The condition of the care environment impacted on people's dignity and quality of life. This was a breach of regulation 10 (1).

The enforcement action we took:

Cancellation of the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The care provider was not working in line with the Mental Capacity Act (2005) or with Deprivation of Liberty Safeguards including those containing conditions. Least restrictive options were not considered. Where people lacked mental capacity, this was not thoroughly assessed or considered. This was a breach of regulation 11 (1)

The enforcement action we took:

Cancellation of the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care provider was not maintaining the condition and safety of the care environment, had poor oversight of medicines management and infection, prevention and control practices, placing people at risk of harm. This was a breach of regulation 12 (1)

The enforcement action we took:

Cancellation of the provider's registration at 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 The care provider was not adhering to local or nationally recognized safeguarding practices and procedures. They were not reporting incidents to the local authority or to CQC in line with their regulatory responsibilities to maintain people's safety and welfare. This was a breach of regulation 13 (1)

The enforcement action we took:

Cancellation of the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The care provider was not ensuring people's nutritional and hydration needs were being safely and appropriately met. Risks were not being well managed. Staff training and provider oversight of this area of care was poor. Monitoring records were of poor quality. There was a lack of choice and health options available. People's weights were poorly monitored. This was a breach of regulation 14 (1)

The enforcement action we took:

Cancellation of the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider have poor oversight of the service, with a lack of governance procedures in place to maintain the safe running of the service. Audits were of poor quality, and were not identifying risks and shortfalls within the service, resulting in people being placed at risk. This was a breach of regulation 17 (1)

The enforcement action we took:

Cancellation of the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The care provider was not completed required pre-employment safety checks to ensure staff could meet the requirements of their job role. The provider had poor oversight of staff, with no audits of HR records being completed. This was a breach of regulation 19 (1)

The enforcement action we took:

Cancellation of the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The care provider did not ensure there were sufficient numbers of suitably trained, and competent staff working at the service to meet people's assessed needs and risks. This was a breach of regulation 18 (1)

The enforcement action we took:

Cancellation of the provider's registration at this location.