Regal Care Trading Ltd

Le Moors

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Le Moors is a residential home which provides accommodation and personal care for up to eight people. Support is aimed primarily at younger adults with a learning disability or autistic spectrum disorder, but the service is also registered to support people with a physical disability, sensory impairment and people living with dementia. Accommodation is provided over two floors, with a lift providing access to both floors. At the time of the inspection seven people were living at the service, all of whom had a learning disability.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

The provider did not have enough staff on duty to enable people to receive personalised care that met their individual interests and supported them to live inclusive lives. A relative told us their family member did not receive enough stimulation or support to access community-based activities. Staff needed to be supported to develop skills in recognised methods to communicate with people with a learning disability or autism. We have made a recommendation about this.

Staff had not been safely recruited. Infection control measures still needed to be improved. The visitor toilet was not fit for purpose. The provider had not ensured risk assessments were in place which considered the increased vulnerability of people living in the home to COVID-19. There was no evidence staff had taken any action to assess and mitigate the risks of people being unable to understand the government guidance they should self-isolate in their bedroom following admission to the home or to maintain social distancing.

The provider had not ensured there were regular checks of the environment. The manager had not completed required fire safety checks or documented the support each individual living in the home would require to evacuate the building in the event of an emergency.

Care records lacked detail about people's interests, wishes and preferences. There was no evidence of goal planning with people who lived in the home to support them to live independent and fulfilling lives. We have made a recommendation about this.

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.

The provider had not always ensured people's ability to consent to their care and treatment in Le Moors had been assessed and applications made for DoLS authorisations where necessary. People in the home were undergoing regular testing in relation to coronavirus but there had been no assessments as to whether this was in their best interests when they did not have the capacity to consent.

The provider did not have effective systems to monitor the quality and safety of the service.

People appeared happy with the staff who supported them. Relatives had no concerns about the safety of their family members in the home and told us staff were kind and caring. Staff understood how to protect people from the risk of abuse. Medicines were safely managed.

The provider worked in partnership with community-based professionals to ensure people's health needs were met. People appeared to enjoy the food staff cooked for them. Staff took appropriate action when nutritional assessments identified the need for specialist advice.

Some improvements had been made to the range of activities available to people within the home. Some easy read information was available to people living in the home, but this needed to be further developed to support people to make their own decisions and choices. The provider had a system to receive and investigate complaints.

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

The last rating for this service was requires improvement (published 28 February 2020) and there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, not enough improvement had been made and the provider was still in breach of regulations.

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.

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

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

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

Why we inspected
This inspection was carried out partly as a result of whistleblowing concerns we had received regarding the care people were receiving in the home. The provider was in the process of investigating these concerns.

Although not part of this inspection, CQC is continuing to investigate the circumstances relating to the death of a person who lived at the service. The information shared with CQC about the incident indicated potential concerns about the management of people's risk of choking. In addition, potential concerns were indicated about staffing levels, staff training and management arrangements at the service. This inspection covered all these areas.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Le Moors on our website at www.cqc.org.uk.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Le Moors

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Although not part of this inspection, CQC is continuing to investigate the circumstances relating to the death of a person who lived at the service. The information shared with CQC about the incident indicated potential concerns about the management of people's risk of choking. In addition, potential concerns were indicated about staffing levels, staff training and management arrangements at the service. This inspection covered all these areas.

Inspection team
The inspection was carried out by one inspector.

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

Although our records showed there was a registered manager in place, they had in fact retired from running the service in December 2020. The provider had appointed a new manager to run the service in January 2021, but they had not applied to register with CQC. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service from the provider since the last inspection, such as details of serious injuries and safeguarding concerns. We sought feedback from the local authority quality and contracting team and Healthwatch Lancashire. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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

We used all of this information to plan our inspection.

During the inspection
We were not able to gain feedback from most people who lived at the service due to their complex needs. On the first day of the inspection, we spoke with one relative, two support workers and the manager from another of the provider's services who had been providing regular support to staff and people living in the home. We also reviewed a range of records, including three people's care and medicines records, three staff recruitment files and a variety of records relating to the management and monitoring of the service. We looked around the home and observed staff providing people with support in communal areas.

We returned to the home on 20 May 2021 to speak with the operations director, who was also the nominated individual; the nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with one person living in the home. We continued to review records relating to the management of the service, including a range of policies, audits and environmental checks.

After the inspection
We spoke by telephone with three relatives and one professional to gather feedback about the service. We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At our last inspection, the provider had failed to ensure there were sufficient staff available to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection, we found insufficient improvements had been made and the provider continued to be in breach of regulation 18

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● The provider did not have enough staff on duty to enable people to received personalised care. The provider had told us in their action plan following the inspection in January 2020 that there would be two staff plus the manager on duty during the day and two staff at night. However, we found there were usually only two staff on duty on each shift, which meant it was not possible for them to support people to access the community on an individualised basis. In addition to caring for people, the provider expected the two staff on duty each shift to cook meals, clean the premises and do the laundry. A relative told us, "Staff are run off their feet as they have to do the cooking and cleaning."

● The provider had a system to assess the dependency levels of people using the service, so that they could determine how many staff were needed each day. However, this dependency assessment focused on people's personal care needs and not their wider social care or emotional needs. In addition, records showed this dependency assessment had not been updated when a person was admitted to the home at the beginning of May 2021; this meant the provider could not be certain appropriate staffing levels were in place to meet the needs of everyone living in the home.

● A relative told us there were not enough staff to always promote positive interaction with people in the home or to support people to undertake activities outside of Le Moors. They commented, [Name of person] doesn't get enough stimulation; that's my main concern. Another relative told us, "[Name of person] is safe but he also needs to feel excited and special." The views of relatives were confirmed by a professional told us the home appeared very institutionalised in its approach to caring for people.

The provider had continued to fail to ensure there were enough staff available to meet people's individual needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had not been safely recruited. Two staff files did not contain references from previous employers. Application forms had not always been fully completed and gaps in people's employment history had not

been noted or explored further on interview. One person's recruitment file did not contain any evidence of questions asked at interview or the person's responses; this is important to check that applicants have the skills to be able to provide appropriate support to people living in the home.

The provider had failed to ensure staff were safely recruited. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection, the provider had failed to ensure people were protected from the risks associated with poor infection control. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, some improvements had been made but the provider continued to be in breach of regulation 12.

● Infection control practices at the service still needed to be improved. A toilet set aside for the use of visitors was unclean, the hot water tap did not work and there were no paper towels available for people to use. In addition, a waste bin in this toilet contained used personal protective equipment (PPE) but did not have a covered lid. The provider arranged for new bins to be purchased following the inspection.
● On the first day of the inspection, there were no disposable aprons for staff to use in any of the bathrooms or toilets we checked; this was immediately rectified by the support manager but no staff had brought this to their attention or taken any action to ensure they had the necessary PPE to use when providing people with personal care.
● Due to their complex needs, people admitted to the home were said to be unable to isolate in their rooms for a period of 14 days in line with government guidance. Although people admitted to the home undertook a lateral flow test and participated in monthly PCR testing, there was limited evidence the provider had considered and documented what other measures could be put in place to mitigate the risk of people being unable to self-isolate or maintain social distancing measures.
● There was limited evidence of effective food safety management practices.

The provider had continued to fail to ensure people were protected from the risks associated with poor infection control. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Cleaning schedules had been introduced since the last inspection. However, these would benefit from being more detailed so that it was clear whether staff had completed all the required tasks.
● Arrangements were in place to support people to receive visits from family members and professionals. However, a relative told us there had been no consideration of their individual circumstances to support flexible visiting. Following the inspection, the provider sent us examples of visitor care plans they had completed.

Assessing risk, safety monitoring and management
● The provider had failed to ensure people were protected from risks relating to the environment. The manager had not completed any checks relating to fire safety and environmental risks such as whether window restrictors were functioning correctly or whether the water temperature in taps was within the correct range to protect people from the risk of harm. In recognition of this, the operations director had completed an audit of these risks in April 2021 and identified actions which needed to be taken. However, it

was not clear who was responsible for these tasks or the time scale for any action to be completed.
● People's care records lacked detail about risks they might experience and what action staff should take to reduce the risk of people coming to harm. As a result of our findings, the provider took action to begin to address this by the end of the inspection.
● Although staff had completed online fire safety training, they told us they had no experience of practice evacuation drills. This meant there was a risk of people coming to harm in the event of an emergency at the home, since staff might not know the correct procedures to follow. The provider had not always completed an emergency evacuation plan for people on their admission to the home. This meant there was no assessment of the support they would need in the event of a fire or other emergency evacuation of the building.

The provider had failed to ensure they were robustly assessing the risks people might experience or to regularly monitor the safety of the environment. This placed people at risk of harm. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At the last inspection, the provider had failed to ensure staff managed people's medicines safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, enough improvements had been made and the provider was no longer in breach of this part of regulation 12.

● People had received their medicines safely and as prescribed.
● Staff responsible for administering medicines had received training and the provider had assessed their competence to carry out the task safely

Systems and processes to safeguard people from the risk of abuse
● The provider had systems to protect people from the risk of abuse. Staff had completed training in safeguarding adults. They were aware of the signs of abuse and how to report any concerns. They were confident the management team would listen to them and take the required action to protect people from the risk of harm occurring.
● Relatives and the professionals we spoke with had no concerns about the care people received in the home. Our observations showed people appeared happy in their environment.

Learning lessons when things go wrong
● The provider had systems to review incidents, complaints and safeguarding concerns. However, our findings showed there was limited evidence lessons learned had been used to improve care in the service.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

● Assessments of people's needs and choices were not very individualised and care documentation lacked information about people's preferences.
● One person's care records contained blank care plans and those completed were very basic in their level of information. Care records we reviewed for two other people were also lacking in detail about how people wanted to live their lives, their interests and how they wanted to be supported. A relative commented about the care provided saying, "It needs to be more person-centred." A family member also told us they thought their family member's communication had deteriorated since they had been in the home. As a result of our findings, the provider took action to begin to address this by the end of the inspection.
● There was little evidence that people's emotional, social, cultural, religious and spiritual needs had been considered during the assessment process.

The provider had failed to ensure people's individual needs and choices were assessed and documented in sufficient detail. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff did not always provide support in line with relevant guidance or the provider's policies. For example, improvements were needed to infection control practices and health and safety matters.

Adapting service, design, decoration to meet people's needs
● People were able to personalise their own bedrooms. People appeared comfortable in their surroundings.

● The provider had made some improvements to the furniture and flooring in the home for the comfort and safety of people who lived there.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The provider had failed to ensure people's rights were always protected by the correct legal framework being in place. One person was unable to consent to their placement in the home, but we were told an application for DoLS had not yet been submitted to the local authority. There was a lack of current information regarding the legal status of other people living in the home. Their care records indicated applications for DoLS had been submitted but there was no information about whether these applications had been authorised.
● People in the home were undergoing regular testing in relation to COVID-19. However, there was no evidence the provider had considered whether people were able to consent to being tested or whether this should be done in their best interests.
● Although staff had completed training in the MCA, there was a lack of understanding about the action they should take if individuals were unable to make particular decisions for themselves. Care records did not always include decision specific mental capacity assessments. There was limited information for staff about how they could support people to make day to day decisions.

The provider had failed to ensure the requirements of the Mental Capacity Act were met. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff training had improved since the last inspection. All staff had completed the training the provider considered mandatory to ensure people received effective care.
● Staff told us they would benefit from additional training regarding supporting and communicating with people who have a learning disability. We noted the provider had arranged for this training to be delivered on a face to face basis following the easing of restrictions relating to COVID-19.
● All staff had recently received supervision from the manager allocated by the provider to support the home. Staff told us they found this manager to be very supportive and approachable.

Supporting people to eat and drink enough to maintain a balanced diet
● The provider had systems to monitor people's nutritional needs and contacted relevant professionals when advice was needed. Staff had a good understanding of people's dietary needs.
● Staff supported people to eat and drink enough. Our observations showed people enjoyed the food provided.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider worked with other agencies to enable people to receive effective care. A professional told us how staff had worked with them to reduce the amount of medicines a person was prescribed.
● Care records included information about people's health conditions and signposted staff to relevant guidance.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- Staff respected people's right to privacy. People's right to confidentiality was addressed during the staff induction and the provider had a confidentiality procedure for staff to refer to.
- Staff promoted people's dignity and privacy. One person told us, "Staff helped me to feel comfortable by having a good chat with me while I had a shower."
- Improvements needed to be made to care records so that they included achievable goals and included information for staff about how to support people to develop skills to promote their independence. The provider told us they were in the process of moving to a new care planning system which they assured us would assist in goal planning with people living in the home.

We recommend the provider consults reputable guidance regarding goal planning to support people with learning disabilities.

Ensuring people are well treated and supported; respecting equality and diversity
- Staff treated people well. Relatives gave us positive feedback regarding the care staff provided. Comments made included, "[Name of person] loves all the staff", "I can't fault it at all; all the staff are excellent" and "[Name of person] is well cared for."
- Staff had received training in equality and diversity. The provider had equality and diversity policies and procedures to guide staff.

Supporting people to express their views and be involved in making decisions about their care
- Staff encouraged people to make decisions about their care when they could such as what they had to eat and where they spent their time. However, we did not see any evidence that easy read and pictorial information was being used to support people to make those choices.
- Relatives told us they had not been involved in any care planning discussion to help make decisions about how staff should provide person-centred care to their family member.
- There was information available for people in an easy read format regarding advocacy services. Advocacy seeks to ensure that people are able to have their voice heard on issues that are important to them.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same. This meant people's needs were not always met.

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

At our last inspection, the provider had failed to ensure staff supported people to follow their interests and take part in activities. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found insufficient improvements had been made and the provider continued to be in breach of regulation 9.

● Staff did not always provide people with personalised care which reflected their needs and preferences. Care documentation included limited information about people's individual likes, dislikes and preferences. Relatives told us they had not been involved in any care plan reviews to help ensure staff supported people in a way which met their preferences and interests. One relative commented, "I have no idea about any care plans."
● In spite of the easing of restrictions and shielding requirements in place due to the pandemic, people were not always offered individualised choices, such as going out or taking part in external activities.
● There was no information on display regarding activities available to people in the community. A relative told us how their family member had enjoyed activities such as bowling, golf and football prior to their admission to the home. There was no evidence the provider had considered how they could enable staff to support this person or others in such community-based activities.
● Staff had developed individualised activity planners for people but these all focused on activities in the home.

The provider had continued to fail to support people to follow their interests and take part in activities outside of the home. They had also failed to provide people with personalised care which reflected their preferences. This was a further breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had made some improvements to the activities which took place in the home.
● People now had access to technology to help them watch videos or play games which they enjoyed. Staff had organised a group outing to the zoo on 19 May 2021 which people had clearly enjoyed.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The provider had an accessible information policy and procedure which set out the actions required of staff to meet the standard.
● Care records contained information about people's communication needs although this was sometimes lacking in detail. Although staff clearly knew people well, we did not see any evidence of them using communication methods such as Makaton or Picture Exchange Communication System (PECS) to help people communicate their needs and choices.

We recommend the provider consults appropriate guidance and support to help staff develop skills in recognised communication methods.

Improving care quality in response to complaints or concerns
● The provider had processes to investigate and respond to complaints and concerns.
● Relatives told us they felt able to raise any concerns with staff. One of the relatives we spoke with had made a complaint. We saw evidence this had been investigated and action taken to address the concerns raised.

End of life care and support
● Care records contained limited information about people's end of life wishes.
● None of the staff had completed training in how to support people at the end of their life. The provider assured us this training would be sought for staff.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

At our last inspection, the provider did not have effective systems in place to ensure the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found insufficient improvements had been made and the provider continued to be in breach of regulation 17.

● Although CQC records showed there was a registered manager in post, they had in fact retired from the service in December 2020. The provider had appointed a manager to run the service in January 2021. However, our findings showed they had not been effective in monitoring the quality and safety of the service.
● The provider had completed an action plan following our last inspection. However, our review of this document and our findings from this inspection showed required actions had not been completed, for example staffing levels had not been increased to three staff during the day, as stated in the action plan.
● There was limited evidence the provider had paid attention to the recommendation made in our previous inspection report relating to the need for staff to encourage people to be as independent as possible. The provider had also continued to fail to apply the principles and values contained in the statutory guidance, 'Right support, right care, right culture'.
● The manager had failed to complete regular health and safety checks, including those relating to fire safety, food safety and the environment. As a result of the risks this presented to people living and working in the home, the nominated individual had completed their own audits of the whole service in April 2021. They had identified numerous areas for improvement, all of which we had also identified during our inspection. However, it was not always clear from the provider's audits who was expected to address the shortfalls or by when.
● The provider had asked a manager from one of their other services to support Le Moors and they had been visiting the home regularly since July 2020. Although they had supported staff to make some improvements, they did not have a clear plan for each of their visits. This meant there was no systematic approach to improving the quality and safety of the service.
● Staff spoke positively about the support manager, although they were less favourable in their comments regarding the home manager. They told us they found it difficult to challenge decisions made by them, for

example a directive that people should be showered twice a day, when they did not feel this was always required and was not in line with people's preferences. A relative also told us the manager had been inflexible in their approach to arranging visits to the home.
● People were not provided with personalised care that met both their health and social care needs, as discussed in another section of this report. There was no evidence of personalised goal planning with people to help promote their independence and emotional well-being.
● The provider was open and honest throughout the inspection. Although they acted on concerns immediately during the inspection and ensured we received further information shortly after the inspection, their own systems had been ineffective in improving care.

The provider continued to fail to have effective systems in place to ensure the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had submitted statutory notifications to CQC about people using the service, in line with current regulations. A statutory notification is information about important events which the service is required to send us by law. The rating from the previous inspection was being displayed.

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 provider had a policy which covered their responsibility under the duty of candour to be honest with people if things went wrong. No incidents had occurred that we were aware of, which required duty of candour action.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There was some easy read information given to people on admission regarding their rights and other material on display in the home. However, the provider needed to further develop this approach to support people living in the home to understand information and express their views.
● The provider had distributed surveys to relatives, staff and professionals in May 2021 but had yet to receive any responses.

Working in partnership with others
● The service worked in partnership with other professionals and agencies to help ensure people received the health care they needed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure the requirements of the Mental Capacity Act were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure staff were safely recruited.