A A Toorabally

The Limes Care Home

Inspection report

Park Road
Mansfield Woodhouse
Mansfield
Nottinghamshire
NG19 8AX

Tel: 01623632681

Date of inspection visit:
09 March 2022

Date of publication:
20 May 2022

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 Limes Care Home is a residential care home providing personal care to 12 people aged 65 and over some of whom were living with dementia at the time of our inspection. The Limes Care Home can support up to 40 people across two floors, due to the number of people using the service only the ground floor was in use.

People's experience of using this service and what we found
Medicines were not managed safely, and people were at risk of not receiving their prescribed medicines. People were not protected from the risk of harm or abuse. Staff did not know how to report or who to report safeguarding incidents too. Risks had not been assessed and risk reduction measures were either not in place or not followed.

Infection prevention control measures were not in place and did not protect people from risk of harm, lessons were not learnt which resulted in incidents being repeated. Safe recruitment practices were not followed which left people at risk of receiving care from unsuitable people.

People did not have their needs fully assessed and care was not delivered in line with best practice guidance and the law. This left people at risk of receiving unsafe care. People were not offered choice in what they wanted to eat, or drink and risks associated with eating and drinking were not managed safely.

People were not always supported by trained staff. Staff had not received training in areas such as safeguarding and moving and handling. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People did not receive personalised care and support. People were not offered choices in how they wished to spend their time and there were no activities on offer. End of life care plans were not in place and there was in delay in seeking medicines and clinical advice for people receiving end of life care.

People were not provided with consistently kind and caring support, they were not given choices or consulted about their care. Staff did not always support people in a dignified way, and they did not always acknowledge people who required support.

The lack of leadership, management and governance measures meant the service was not well led. This meant people were at risk of receiving care which placed them at risk of harm in an unsafe environment. Lessons were not learnt, and this resulted in repeated incidents which placed people at risk of harm.

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 inadequate (published 22 April 2022)

and there were multiple breaches of regulations. At this inspection we found improvements had not been made and the provider remained in breach of regulations.

Why we inspected
The inspection was prompted due to concerns about staffing, management, infection control, and how people were safeguarded from the risk of neglect. Due to the increasing concerns a decision was made for us to inspect much sooner than planned and examine those risks.

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

We have found evidence that the provider needs to make improvements. Please see the full report.

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

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

Enforcement
We have identified breaches of regulations in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, staffing, fit and proper persons employed, person-centred care, nutrition and hydration, dignity and respect and good governance.

We took urgent enforcement action to ensure people were kept safe from harm and suspended the providers registration, all people living at the service moved out of the home following our inspection.

Due to the repeated breaches and failure to make improvements to exit special measures enforcement action was taken against the provider to remove their registration.

Follow up
We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures: The overall rating for this service is 'Inadequate' and the service remains 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 of their 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 Limes Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
The Limes Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Limes Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. 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 since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us

to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with seven people who used the service about their experience of the care provided. We spoke with six members of staff including the deputy manager, senior care workers, kitchen staff and care workers. We spoke with three visiting professionals and two relatives about their experience of the care provided at the home.

We reviewed a range of records. This included six people's care records and multiple medicine records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including training records, policies and procedures were reviewed.

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 inadequate. At this inspection the rating for this key question has remained 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 safely recruit suitably qualified and competent staff. This was a breach of both regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 and regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 18 and regulation 19.

● The provider did not ensure there were always sufficient suitably qualified staff deployed to meet people's needs safely. New staff continued to be recruited unsafely.
● We identified staffing numbers were not sufficient to meet people's needs or keep people safe. We observed people to be shouting out for help throughout the day and people were left in soiled pads as there were no staff to support them. During the inspection due to the level of concerns for the safety of people, staff from the local authority attended the service to ensure people were safe and their needs could be met.
● Staff morale was low, staff we spoke with told us there was a blame culture in the service and they did not feel they could raise concerns to the manager or provider. For example, one staff told us, "I've had enough, if it wasn't for the people living here, I would walk out, the managers don't listen, the problems are always someone else fault."
● Staff were promoted to senior roles without an interview or any further training to ensure they were suitably qualified for the role. Essential safety checks such as a Disclosure and Barring Service check prior to starting employment were not in place for all staff at the time of our inspection. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The lack of safety checks placed people at risk of receiving unsafe care from unsuitable people.
● Staff worked exceptionally long hours some in excess of 80 hours a week. Staff told us they had cancelled planned time off as there were no other staff available to provide care to people. Staff also told us they felt overwhelmed and tired. For example, one staff told us, "To be honest I feel like I live here, I'll need to move in soon." This places people at risk of receiving unsafe care from over worked staff.

The provider had failed to ensure sufficient staff were deployed at all times and to recruit staff safely. This was a continued breach of both regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 and regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection the provider had failed to safeguard people from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 13.

● There were no systems in place to protect people from the risk of abuse or neglect.
● Staff failed to recognise incidents as neglect and abuse. For example, we found one person in a very unkempt distressing state, we reported this to staff immediately who advised the person neglected themselves. Staff failed to take any action to manage the person's needs. Staff failed to recognise this as a safeguarding concern. This placed people at risk of neglect and abuse.
● The provider had taken insufficient action following our last inspection and continually failed to ensure safeguarding concerns were recognised, recorded or reported appropriately to the local authority safeguarding team or to the Commission as is required by law. This placed people at risk of continued abuse.
● Lessons were not learnt from and little or no action was taken following incidents occurring. For example, concerns and incidents relating to pressure area care highlighted at our previous two inspections had not been learnt from and incidents relating to poor pressure area care were repeated. This placed people at risk of harm.

The provider failed to ensure that people were protected from abuse and improper treatment. This was a continued breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people, manage medicines safely and ensure infection prevention control measures were effective. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

● Risks were not assessed, managed or monitored in order to keep people safe from harm. Risks associated with people's healthcare needs were poorly managed.
● Risk assessments and care plans were either not in place or inaccurate for people living with skin damage and wounds. For example, a person living with a necrotic wound had no care plan in place to instruct staff how to care for them. There were no skin or wound monitoring records in place which resulted in a significant delay in seeking specialist advice. This placed people at risk of further skin and wound deterioration.
● Risks associated with diabetes and excessive alcohol consumption were not assessed or managed. This placed people at risk of harm.
● Environmental risks continued to be poorly managed, monitoring of water temperatures had not been completed and all taps were thick with limescale. This increased the risk of scalding, legionella and other

water-borne pathogens. This placed people at risk of harm.

Systems had not been established to robustly assess the risks relating to the health safety and welfare of people. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to manage medicines safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

● Medicines were not managed safely this placed people at risk of not receiving their prescribed medicines.
● People did not always receive their prescribed medicines. We found medicines on the floors of people's bedrooms, staff were unaware how long these medicines had been there or what they were.
● Medicines were not stored correctly or safely. For example, we found rescue medicine for chest pain without a prescription label in a person's medicine storage basket, staff did not know if this medicine was meant for this person.
● There continued to be missing records in place relating to medicines which were required 'as needed'. For example, some of these medicines included rescue medicines for chest pain. This meant staff did not have instructions in how to safely give these types of medicines for each person or when to give them. This placed people at risk of harm.

Systems had not been established to ensure medicines were managed safely. This placed people at risk of harm. This was a continued breach of regulation 12 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 infection prevention control measures were effective. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

● People were at risk of infection due to poor infection prevention and control practices. The home was experiencing an outbreak of COVID-19 which exacerbated those risks.
● The home was visibly dirty and there was a strong malodour throughout the home. Carpets throughout the building were in disrepair and unclean. Bedrooms including furniture which were both in use were found to be very dirty, some were soiled with urine and faeces. Cleaning records were found to be inaccurate or incomplete.
● Best practice guidance was not followed to help reduced the risk of COVID-19. For example, people who were COVID-19 positive were not kept isolated in either their own rooms or cohorted in a specific part of the building to minimise the risk of infection spreading.
● The laundry room was unclean. There was no clear guidance on separating dirty or contaminated linen

from clean linen. Inspectors found a duvet which was grossly contaminated with faeces draped over a washing machine. Both washing machines were visibly dirty and one of them was leaking.
● The continued lack of infection and prevention control measures in place left people at risk of spreading and contracting healthcare related infections. This placed all people at risk of harm.

Visiting in care homes
● There were restrictions on visiting the service due to a COVID-19 outbreak which were in line with current government guidance. Essential care givers continued to visit the service. There was no system in place for staff to follow to ensure essential care givers had the relevant COVID-19 checks done before entering the building. This put people at risk from catching COVID-19.

Systems had not been established to ensure infection prevention control measures were effective. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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

The provider had failed to ensure people care and support in line with their assessed need which placed people at risk of harm. This is a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's needs had not been fully assessed and records were not in place to enable staff to support people safely.
● Records contained inaccurate information and were not updated when people's needs changed. For example, a person who had sustained a number of falls and had become injured following these falls had not been reassessed or had their care plans updated. Staff did not have accurate information to safely support people which placed them at risk of harm.
● Records did not demonstrate people's needs had been assessed in line with best practice guidance. For example, nationally recognised screening tools for pressure area care and nutritional monitoring were not in place for many people. This placed people at an increased risk of harm.

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

The provider had failed to work with other agencies to ensure people received timely care and support in line with their assessed need which placed people at risk of harm. This is a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's health needs were not managed effectively.
● The provider failed to make referrals to health and social care professionals when specialist advice was needed. For example, a person who regularly declined care and support and had known health needs prior to moving into the service was observed to be frail and in a distressing state. The provider had taken no action to support the person or sought specialist advice in order to manage known health conditions.
● Staff did not act in a timely manner in seeking care and support when people became unwell. For example, staff failed to document and escalate that a person had become unwell during the night. The person approached the inspection team seeking support. This was escalated to staff and emergency services called. Due to poor documentation and an initial failure to escalate concerns, there was an avoidable delay in staff seeking medical attention. Failure to recognise and act when people become unwell

placed people at risk of harm.

Staff support: induction, training, skills and experience

The provider failed to ensure staff were competent to provide safe and effective care this is a breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Induction and training programmes were not in place staff.
● Staff new to the service did not have an adequate induction or any practical training prior to commencing work. For example, staff who had commenced employment on 7 March 2022 and who was working independently had received no practical training or competency assessments to ensure their practice was safe. Furthermore, a second staff member who had been in charge of the home confirmed they had not completed their training. They did not complete the required safety checks when letting Inspectors into the building evidencing further training was required.
● There were not enough suitably trained staff to effectively supervise new staff members which placed people at risk of receiving unsafe care from untrained staff.
● The provider failed to ensure staff received regular supervisions to identify any training or support.

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

The provider failed to ensure peoples nutrition and hydration needs were met this was a breach of regulation 14 (meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not always supported effectively to eat and drink in order to maintain a balanced diet.
● People told us they were not consulted in what they would like to eat or drink. For example, one person told us, "The food is very repetitive, constant sandwiches, which I don't really like."
● We found there was not enough food in the building during our inspection which could be eaten safely. The local authority delivered meals during our inspection to ensure people had food which was safe to consume.
● People told us they waited long times for food and drink. For example, one person told us, "I have asked and asked this morning, and no one has brought me my breakfast and just a cup of coffee, it's been over two hours, I'm not asking for much." Furthermore, we observed one person to be nursed in bed with their door closed who could not verbally communicate and they did not have access to a call bell, to be left throughout the day without any water. Staff who were present from the local authority ensured that all people living at the home received food and drink.

Adapting service, design, decoration to meet people's needs
● The premises and environment had not been adapted to ensure people's needs were met.
● People's bedrooms were sparsely furnished and dirty. Most people's bedrooms did not reflect any personal preferences.
● There was little signage around the home to direct people living with dementia to areas such as bathrooms. A menu on display had an incorrect date of over four months. This placed people living with dementia at risk of disorientation.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People's rights under the MCA were not always respected and where people lacked capacity to consent, mental capacity assessments had not always been completed for specific decisions. For example, a person living with vascular dementia had no mental capacity assessments completed.
- DoLS were in place for people who required them, however some had expired, and we could find no evidence these had been reapplied for.

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.

Supporting people to express their views and be involved in making decisions about their care

The provider failed to ensure people received care in a person-centred way. This is a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We found little evidence that people had been involved in making decisions about their care.
- We found people were spoken at rather than to. For example, we observed a person trying to explain they felt unwell to staff, this was disregarded, and staff told them to have a cup of tea and sit in the lounge.
- The provider did not ensure staff had time to sit, talk and listen to people. The provider did not encourage people to express their views. People told us, "We get no say, I keep quiet as I don't want to get in to bother."

Ensuring people are well treated and supported; respecting equality and diversity

The provider failed to ensure people were treated well. This is a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were not always treated well or provided with support when requested.
- We observed staff to sit in the office for long periods of time ignoring call bells and peoples calls for help. We observed one staff member to ignore an emergency call bell remaining seated in the office whilst this alarmed.
- Staff directly ignored peoples call for help. For example, a person approached the inspection team requesting immediate support, we approached staff who ignored our requests and continued to show visitors round.
- We observed a lack of interaction and engagement. People who were unable to mobilise independently were left in bedrooms without any engagement from staff for very long periods of time. Whilst we also observed people sat in lounges with little interaction from staff.

Respecting and promoting people's privacy, dignity and independence

The provider failed to ensure people were supported in a caring, dignified and respectful way. This is a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed people to be left in undignified positions and one person was left in a state of undress. We found people to be left in soiled pads for long periods of time which were visible through their clothes. This was undignified and did not respect their right to privacy.

● We observed people to be wearing ill-fitting and dirty clothes. People told us their clothes had gone missing. For example, one person requested our attention in their bedroom, they were very upset and told us, "All of my clothes are gone, they do nothing when I ask them where they are, I only have what I am wearing."

● Staff spoke about people's personal care needs in corridors and in lounges. This did not respect people's right to privacy.

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 requires improvement. 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; End of life care and support

The provider failed to implement care to ensure people's personal preferences and needs were met. This is a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People did not receive personalised care and support tailored to their needs and preferences.
- Staff were not aware of peoples likes and dislikes. For example, one person told us they were repeatedly given food they did not like.
- Care plans were not detailed and did not direct staff how to support people safely according to their needs. For example, care plans for people who lived with mental health conditions failed to instruct staff how to care for them to ensure their needs were met.
- Care plans relating to end of life care were poor and lacked detail. This placed people at risk of not getting the support they require or want at the end of their lives.
- Staff did not act in a timely manner to ensure a person who was receiving end of life care was comfortable. For example, there was a delay in the home obtaining and implementing clinical advice, equipment and medicines. This placed the person at risk of avoidable pain and discomfort.

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

T

he provider failed to implement care to ensure people's personal preferences and needs were met. This is a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were not supported to choose or engage in any activities.
- There were no activities on offer. People told us they were bored and often felt lonely, "There's nothing to do, I'd like someone to talk to, but we get nothing."
- The provider had not considered or taken any action to ensure people maintained relationships with their family and friends when the home was closed due to an outbreak.

Meeting people's communication needs

The provider failed to implement care to ensure people's personal communication preferences and needs

were met. This is a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 plans did not always contain clear information about how people communicated.
- People were not always given information in a way they could understand. For example, staff told us, and we observed that although some people had a cognitive impairment, people were only offered verbal choices and people who were hard of hearing were shouted at. Staff did not use any other resources such as pictures to communicate with people.

Improving care quality in response to complaints or concerns

The provider failed to ensure systems were in place to monitor and respond to concerns to ensure quality of care improved. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had a complaints policy in place however we found that no complaints or concerns had been documented.
- Relatives and people, we spoke with told us they had raised concerns, but we could find no evidence these had been investigated by the provider.
- Little action had been taken following concerns raised by the local authority and concerns found at previous inspection to improve the quality of care.

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 inadequate. The rating for this key question has remained 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection the provider had failed to monitor and drive service improvement in order to provide safe care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had not been made at this inspection and the provider remained in breach of regulation 17.

- The culture was not person centred, open or inclusive. This meant people were at risk of receiving poor care.
- There was blame culture at the home and a lack of accountability from the manager and the provider. Issues at the home were long standing however these issues were attributed to individual members of staff.
- The culture of the home had resulted in low staff morale and a high turnover of staff. This had a negative impact on the quality of care people received. For example, people told us, "Staff are here one day and gone the next, you just never know who's here."
- There were no meetings held with people, their relatives or staff to discuss the service or to offer support.
- Care plans we reviewed did not evidence people or their relatives had been involved in planning or making decisions about their care.

The provider had continued to fail to monitor and drive service improvement in order to provide safe care. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to ensure systems were in place to monitor and drive service improvement in order to provide safe care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had not been made at this inspection and the provider remained in breach of regulation 17.

● Failings found at our previous inspections had seen minimal improvements, we received significant concerns relating to the safety and welfare of people following our last inspection in February 2022, which meant we returned much sooner than anticipated.
● The provider had continually failed to learn from previous issues raised. The provider had failed to implement systems in order to drive service improvement. For example, there were no systems or processes in place to ensure the service did not run out of vital supplies such as food and cleaning supplies.
● Audits were not accurate therefore did not identify risk. For example, infection control audits did not accurately reflect what we found during our inspection.
● Lack of managerial oversight of care records meant these were not consistent or accurate. For example, we found records that had been completed by staff who were not in the building at the time care had been documented as being given. This placed people at risk of harm.
● Management at the home was not stable and there had been a further change in management at the service since our last inspection. Staff were not clear about their roles. Job roles changed frequently with little management oversight to ensure staff were qualified or supported in their new roles.

The provider had failed to learn, monitor and improve the quality and safety of care. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others; 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

At our last inspection the provider had failed to seek and act on feedback to improve the quality of care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had not been made at this inspection and the provider remained in breach of regulation 17.

● The provider did not always refer to health and social care professionals in order to seek specialist advice. This placed people at risk of harm.
● A professional we spoke with told us there had been a delay in implementing equipment, whilst another told us there had been a significant delay in seeking specialist advice as directed by a medical team. Failure to implement care and seek professional advice placed people at risk of harm.
● People and their relatives had not been informed of the findings of our last two last inspections and no assurances had been offered to people or their relatives of what action the provider would take to ensure the service was safe.
● The lack of investigation, poor oversight and continued failure to report safeguarding concerns indicated that the provider was not fully aware of their legal responsibility to be open and honest with people.

The provider had failed to seek and act on feedback in order to improve care. This was a continued 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 People did not receive personalised care and support which left people at risk of harm.

The enforcement action we took:

We urgently suspended the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always supported in a dignified or respectful way.

The enforcement action we took:

We urgently suspended the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at significant risk of harm from poor risk management and their environment. Medicines management was poor. Infection control practices were not in line with guidance leaving people at significant risk of infection during the pandemic.

The enforcement action we took:

We urgently suspended the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure there were adequate safeguarding processes and systems in place to safeguard people from the risk of abuse and harm.

The enforcement action we took:

We urgently suspended the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to effectively support people to eat and drink in order to maintain a balanced diet.

The enforcement action we took:

We urgently suspended the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure there was effective leadership in place. There were not effective systems and processes in place to assess, monitor and improve the quality of care.

The enforcement action we took:

We urgently suspended the providers registration.

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 failed to ensure staff were recruited safely.

The enforcement action we took:

We urgently suspended the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there was adequately trained staff deployed to meet peoples needs.

The enforcement action we took:

We urgently suspended the providers registration.