Kind Hands Limited

Bournedale House

Inspection report

441 Hagley Road
Birmingham
West Midlands
B17 8BL

Tel: 01214204580

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

Summary of findings

Overall summary

About the service
Bournedale House is a residential care home providing personal care for up to 11 people who may be living with dementia. At the time of the inspection, nine people were living at the home.

People's experience of using this service and what we found
We found significant concerns in relation to the infection prevention and control (IPC) practices within the service. People's medicines were not always managed and administered safely. The provider had not adhered to safe recruitment practices. Staff told us they had not received any supervision or enough training to meet people's individual needs. The provider did not have robust procedures and processes in place to protect people from the risk of abuse. Risk assessments had not always been completed in relation to known risks to people or plans developed for managing these risks

People's needs and choices had not always been appropriately assessed before they moved into the home to ensure effective outcomes of their care. People were not always supported by staff who had the skills and knowledge to meet their needs. People's individual dietary needs were not always addressed. People did not always have timely access to healthcare services and support. The physical environment had not been adapted to the needs to people living with dementia. The provider was not working in line with the principles of the Mental Capacity Act 2005.

People were not always well treated. People's relatives expressed mixed views about how staff treated their loved ones. People's independence was not always fully promoted. We were not assured staff had the time to listen to people and involve them in decisions.

People's care plans were not person-centred to help staff ensure they received personalised care. They did not provide staff with clear guidance on how to meet people's individual needs. People were not supported to follow their interests or take part in meaningful activities, and they showed signs of boredom. The provider did not have a complaints policy or systems to record or respond to complaints.

We were not assured the provider or manager understood regulatory requirements. The provider did not have effective quality assurance systems and processes in place. The provider had not established robust systems and processes to enable staff to record and report accidents or incidents. Records relating to people's care were not always accurate. The provider had not actively sought the views of people, relatives, staff or visiting professionals on the service. We were not assured the provider or manager understood their responsibilities under the duty of candour.

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

This service was registered with us on 21st January 2022 and this is the first inspection.

Why we inspected
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. This included checking the provider was meeting COVID-19 vaccination requirements.

The inspection was prompted in part due to concerns received about infection control and medicines management. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well Led sections of this full report.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to person centred care, safe care and treatment, safeguarding people from abuse and improper treatment, receiving and acting on complaints, good governance and staffing at this inspection.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Bournedale House

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 included checking the provider was meeting COVID-19 vaccination requirements. 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
Bournedale House 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.

The service did not currently have a manager registered with the Care Quality Commission. We met with the manager, who had not yet applied to register with the Care Quality Commission. The 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. 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 used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with two people who used the service about their experience of the care provided. We spoke with the manager, deputy manager and three members of care staff including night care staff and the cook.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke to three members of staff and three family members of people who use the service.

Inadequate

Is the service safe?

Our findings

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. There was no robust cleaning schedule in place to include frequently touched areas in the home. The lack of regular cleaning to reduce the risk of infection was evident. For example, we saw what appeared to be faecal matter on shower chairs, toilet seats and sinks.
- People were placed at risk of increased transmission of COVID-19 due to shared equipment and communal areas not being thoroughly cleaned following each use.
- The provider had not ensured all staff received infection control training to ensure they understood their associated roles and responsibilities
- We were not assured that the provider was preventing visitors from catching and spreading infections. Although the provider had a visiting protocol designed to keep people safe, this was not consistently followed by staff. On arrival, we were greeted by a staff member who was not wearing a mask. We were not asked about our COVID-19 vaccination status, nor was there a request to see our lateral flow device (LFD) result.
- We were not assured staff were using and disposing of personal protective equipment (PPE) effectively and safely. We observed staff not wearing masks or wearing these incorrectly, for example under their chin. We raised this with the staff involved and the manager who immediately addressed the issue. Staff were observed putting on and taking off PPE incorrectly. We observed used gloves disposed of in waste bins. PPE stations were not consistently stocked with necessary equipment and no clinical waste bins were available at these stations to safely dispose of PPE. This practice increased the risk of infection transmission and was not in line with current IPC guidance.
- The provider had not completed individual COVID-19 risk assessments for people or staff. This was a concern as some people living at the service had complex health conditions and were at increased risk from the complications associated with COVID-19.

We found no evidence that people had been harmed however, the provider had not taken reasonable steps to protect people from the risk of infections. 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.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Using medicines safely

● People's medicines were not always managed and administered safely to ensure they were not placed at risk.

● People did not always receive their medicines in line with prescriber's instructions. For example, one person's medication administration record (MAR) indicated staff had administered a medicine every day, when the instructions on the MAR stated it was to be given every other day. Another person was prescribed a cream which was to be applied twice a day. We found there were multiple gaps on the MAR chart indicating the medication had either been given once per day or not at all.

● We checked the stock of people's medicines and identified discrepancies which the manager and deputy manager were unable to account for. For example, one person's MAR indicated they had received three doses of a controlled medicine, but four doses had been dispensed from the medicine packaging. A controlled medicine has potential for harm or misuse so extra safety measures are needed to make sure they are prescribed, supplied, used and stored safely and legally.

● The information recorded on people's MARs was not always accurate. For example, staff had signed to indicate one person had been administered their medication when this had not yet been given. This increased the risk of medication errors.

● Not all staff involved in handling and administering people's medicines had received training in the provider's medicines procedures.

● Medicines were not stored securely; we found the keys to the medication trolley left unattended, which increased the risk of unauthorised access to people's medicines.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety in the management and administration of medication. 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.

Staffing and recruitment

● The provider had not adhered to safe recruitment practices. This placed people at risk of being supported by unsuitable staff.

● We reviewed three staff members' recruitment records and found the provider had not completed consistent pre-employment checks to check their suitability to work with people. There was no record of a Disclosure and Barring Service (DBS) check for any of the three members of staff, and one of these staff had no recruitment file in place. The DBS helps employers make safe recruitment decisions by checking the criminal records of potential employees.

The provider's failure to operate robust recruitment practices was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people's relatives expressed concerns about staffing arrangements at the service during the night. We found the provider had no systematic approach in place to determine the necessary staffing levels required to support people in the home safely and ensure their needs were met.

● Some staff we spoke with told us they had not received any supervision or enough training to meet people's individual needs. One staff member said they, "I do not feel I am having enough support to do my job or have had enough training."

Systems and processes to safeguard people from the risk of abuse

● The provider did not have robust procedures and processes in place to protect people from the risk of abuse.

● Not all staff had received safeguarding training to ensure they knew how to identify and report abuse concerns. Some staff we spoke with lacked understanding of the different forms of abuse and their associated responsibilities.

● During the inspection, we were made aware of an incident where a member of staff had verbally abused a person living in the home. This incident had been witnessed by staff and brought to the attention of management. The provider had not investigated this or taken further action to safeguard the person, including notifying the relevant external agencies. The manager took action when we raised our concerns with them.

● The provider had also failed to take appropriate action following an allegation of neglect involving a staff member to ensure people were safe.

● The provider had no system in place for monitoring the progress or outcomes of applications for Deprivation of Liberty Safeguards (DoLS) authorisations. We found three people's DoLS authorisations had expired and not been reapplied for without a clear rationale. This meant some people who were unable to consent to their care may be being deprived of their liberty without authorisation from the local authority. The manager told us they were unaware of how to make a DoLS referral as they had never completed one before.

The provider's lack of robust processes to ensure people were safeguarded from abuse and improper treatment 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; Learning lessons when things go wrong

● Risk assessments had not always been completed in relation to known risks to people or plans developed for managing these risks. For example, one person had been assessed as being at high risk of falls, however staff had not been provided with clear guidance on how to minimise this risk.

● Where people had long-term medical conditions, plans were not always in place for managing these. For example, one person had been diagnosed with a long-term physical health disorder. Staff had not been provided with information about this disorder and the person's care plan did not explain how this was being managed.

● Staff had not been provided with training in relation to people's individual health needs and their role in monitoring and helping people to manage these.

● Some staff we spoke with were not aware how to access people's care plans and lacked understanding of what these contained. This increased the risk of people receiving inconsistent and unsafe care.

● People's risk assessments were not reviewed or updated following incidents involving them. For example, one person had had two falls within the last month recorded in their care notes. The falls assessment tool for this person had not been updated following either incident or details of any actions taken to mitigate the risk of similar occurrences recorded. Another person's care notes referred to two recent incidents of potential self-harm. No actions had been recorded in response to these incidents. The person's care plans made no reference to the potential for self-harm or the plans for managing this risk.

● Incidents affecting people's health, safety and wellbeing were not always reviewed and thoroughly investigated. We saw entries in seven people's care notes indicating particular incidents had been recorded on an incident form and reported to management. However, the registered manager was unable to locate the relevant incident forms to confirm these had been reviewed and investigated.

We found no evidence that people had been harmed however, systems were either not in place or robust

enough to demonstrate safety was effectively managed. 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.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

- People's needs and choices had not always been appropriately assessed before they moved into the home to ensure effective outcomes of their care. Pre-admission assessments were not sufficiently detailed and did not consider peoples' physical, mental and social needs.
- Once people moved into the home, their care needs, choices and preferences were not regularly reassessed. For example, one person's current mental health needs had not been assessed and their care plan provided no guidance for staff on how to effectively support them in this area.
- There was limited evidence in people's care records of staff having worked with other agencies to ensure people's needs were met.

Staff support: induction, training, skills and experience

- People were not always supported by staff who had the skills and knowledge to meet their needs.
- The provider did not have an effective system in place for assessing, monitoring and addressing staff training needs. Most staff had not received training identified by the provider as required, or this had training expired. For example, only three out of 12 staff had completed the provider's annual safeguarding training in the last year. In addition, staff training provision did not take into account people's individual physical and mental health needs.
- Some staff we spoke with felt the training they had received was not effective in enabling them to meet people's needs. One member of staff said, "[I have] not had enough training to do my job. I enrolled on a private course in care to further my knowledge." Another member of staff stated, 'The training is all online; it isn't as good as having a trainer on site."
- The provider's staff induction did not incorporate the requirements of the Care Certificate. The Care Certificate is aimed at ensuring health and social care staff have the knowledge and skills they need to provide people with safe and compassionate care.
- Staff did not receive regular supervision to monitor and reflect on their practice, provide guidance and support, and identify areas for development. There were no records of supervision in staff files. One member of staff who had worked at the home for three months told us, "I have not had any support whilst I've been working here. I've not had a supervision, one to one, appraisal or probationary review."

Staff had not consistently received the support, training, supervision and appraisal necessary to enable them to carry out their duties. 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

● People were not fully supported to make decisions about what they ate and drank. People were not involved in menu planning and menus were not made available to people in advance of mealtimes to help them choose between the two available meal options.

● People's individual dietary needs were not always addressed. One person was prescribed a dietary supplement designed for the dietary management of people with, or at risk of, disease-related malnutrition. This was to be administered once per day, however we found that the supplement had only been signed for on three occasions over the previous 17 days.

● We found that mealtimes were unusually early and not appropriately spaced, to prevent people from having to wait too long between their meals. Lunch was typically served at 12:30 and dinner at 16:30.

Supporting people to live healthier lives, access healthcare services and support

● People did not always have timely access to healthcare services and support. One person had experienced a deterioration in their mental health, but we found no evidence an appropriate referral had been made in response to this. Staff had not sought appropriate medical advice for another person following a fall.

● People's relatives told us they were not kept up to date with changes in their loved ones' health. This meant people had less support to understand and be involved in decision-making about their health. For example, one person's relative told us they had not been informed of a serious incident involving a deterioration in their loved one's mental health or involved in any associated decisions.

Adapting service, design, decoration to meet people's needs

● The physical environment had not been adapted to take into consideration the needs to people living with dementia and there was a lack of signage in place to support people to navigate around the home. There were no memory boxes to help people recognise their own rooms. This meant people could not easily orientate themselves within the home. In addition, there was a lack interactive or dementia-friendly resources within the home. Clocks around the home were also set to incorrect times. This meant people who are living with dementia or who are not orientated with time could become even more confused.

● The home's heating system had not been functioning correctly for an extended period. We found some people's rooms had no working central heating, although they had been provided with portable heaters. The provider confirmed the heating was not fully functional and informed us work was ongoing to identify the fault.

● Some people's relatives spoke negatively about the maintenance of the premises and the degree to which the standard of accommodation reflected what they would expect for loved ones. One relative described their relative's room as "disgusting". Another relative stated the home was "dated and shabby". A further relative described the home as being, "in a state of disrepair".

● At the time of the inspection the main lounge was closed due to being redecorated. The provider had not put a plan in place to provide people with an alternative communal area. This meant people had reduced opportunities for social interaction.

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.

● The provider was not working in line with the principles of the MCA. They were unable to evidence that people's rights under the MCA were being protected. Assessment and care planning processes did not always consider people's capacity to consent to care and treatment.
● Where people were unable to make particular decisions, mental capacity assessments had not always been completed or, where completed, these had not been kept under regular review.
● Where it had been established people lacked capacity to make a particular decision, best-interests decision-making had not always been recorded. For example, one person's care plan stated best-interests decisions were needed in relation to multiple areas of their care, including personal care, medication and personal finances. No further information had been recorded regarding associated best-interest decision-making.
● The information recorded about people's ability to make their own decisions was sometimes contradictory. For example, one person's care plans included contradictory statements about their capacity and the need for a DoLS authorisation.
● The provider had failed to consistently identify people who required a DoLS referral to be made to seek authorisation to deprive them of their liberty. This meant some people who were unable to consent to their care may be being deprived of their liberty without authorisation from the local authority.
● The management team and staff lacked understanding of people's rights under the MCA and their associated responsibilities. We were not assured staff fully supported people to make day-to-day decisions, including how they wished to spend their time. We observed staff repeatedly encouraging people to return to their rooms instead of supporting their choice to engage in alternative activities.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated Inadequate

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; respecting and promoting people's privacy, dignity and independence

- People were not always well treated. People's relatives expressed mixed views on the extent to which staff knew people well and treated them with kindness and compassion. One person's relative told us, "The staff made [relative] feel really welcome and I was impressed with their interactions with [person's name]." However, another relative told us, "They [staff] seem to treat [person's name] really bad." We were made aware of an incident in which a staff member had verbally abused a person living at the home, which had not been investigated or addressed by management.
- People's independence was not always fully promoted. Limited efforts had been made to create a dementia-friendly environment, including the installation of appropriate signage to help people living with dementia to navigate the home independently. We saw a daily routine on the staff bulletin board detailing when certain care tasks should be completed with people. There was no evidence that this routine was led by people's individual needs or preferences.
- We observed staff speaking with people with affection and treating them with dignity and respect. Staff used people's preferred names. One staff member told us, "The carers really care about the people; all the staff do their best." Staff took practical steps to protect people's dignity, such as ensuring doors were closed when supporting people with their intimate care.
- Most people's care records were electronic and password-protected to restrict access to these to the authorised persons.

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

- We were not assured staff had the time to listen to people, answer their questions and involve them in decisions. We saw staff were busy and task-focused.
- People's care records, including records of care reviews, did not demonstrate people and their relatives were involved in decisions about the care provided. People's relatives told us the provider had not involved them in care reviews, which meant they did not have the opportunity to contribute towards decisions about their loved ones' care.
- The provider could not provide us with evidence they had actively sought feedback from people living at the service, relatives or staff members. The manager told us they had not sent out any questionnaires or feedback forms. This was confirmed by people's relatives. This meant people, their relatives and staff had limited opportunities to express their views about the care provided and how this might be improved.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People's care plans were not person-centred to help staff ensure they received personalised care. Care plans did not include details of people's personal history, individual preferences or interests. Some people's relatives felt staff lacked understanding of their loved ones' likes and dislikes.
● People's care plans did not provide staff with clear guidance on how to meet their individual needs. This included a lack of information about the management of some people's physical and mental health needs, including long-term conditions such as Parkinson's or the impact of dementia. For example, the care plans for one person with complex health needs contained no information for staff about the nature or impact of particular health conditions or what they should do in monitoring these conditions.
● People and, where appropriate, their relatives were not encouraged to contribute towards care planning. One person's relative told us "I have never been asked to attend a care planning review or asked about [person's] needs". Care plans did not demonstrate people and their relatives had contributed towards the planning of care.
● Some staff told us they did not have access to people's care plans and were uncertain how to access these on the provider's electronic care planning system. They told us they had to rely on information from colleagues and staff handover meetings to understand people's care needs and any changes in these. This increased the risk of people receiving inconsistent care that was not person-centred and did not reflect their individual needs. We found some staff lacked awareness of people's current care needs.
● People were not supported to follow their interests or take part in meaningful activities, and they showed signs of boredom. During the inspection, we did not observe any structured social or leisure activities taking place within the home. People's care records did not indicate such activities routinely took place. The provider did not employ dedicated activities staff and the manager told us there was no activities plan in place.

Systems for ensuring people's care and treatment was appropriate, met their needs and reflected their preferences were not being used effectively. This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the time of our inspection, there was no communal space within the home for people to access. The communal lounge was closed for redecoration and no alternative arrangements had been put in place for people to socialise with others and reduce the risk of social isolation.

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.

● The manager lacked understanding of the provider's responsibilities under the Accessible Information Standard.

● People's information and communication needs had not been explored with them, recorded or communicated to staff to promote effective communication.

● The provider did not provide information in alternative accessible formats to ensure people, including those living with dementia, had information they could access and understand.

Improving care quality in response to complaints or concerns

● The provider did not have a complaints policy or systems to record or respond to complaints.

● The deputy manager made us aware of a complaint which had recently been received but the provider had no record of the complaint or how they had dealt with it.

● Some people's relatives told us their complaints had not been dealt with satisfactorily by the provider. One relative told us, "I have made lots of complaints and none have been acted on. You have to push them [provider] constantly before they do anything."

Systems for ensuring complaints are investigated was not in place. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● At the time of our inspection, no one living at the service was receiving end-of-life care.

● We saw no evidence in people's care plans that their wishes and preferences regarding their end-of-life care had been discussed with them, and their relatives where appropriate, or recorded. This meant these wishes and preferences may not be met by the provider.

Inadequate

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- We were not assured the provider or manager understood regulatory requirements or kept themselves up to date with these, including the need to notify CQC of relevant changes, events and incidents affecting the service and the people using it. For example, the provider had failed to notify us of a safeguarding concern involving a person who used the service.
- Staff did not have regular supervision, to receive feedback on their performance and constructive feedback on how this might be improved.
- The provider had no formalised or effective quality assurance systems and processes in place and lacked overall oversight of the standards of safety and quality of people's care. As a result, they had identified or addressed the significant shortfalls in the quality and safety of people's care we identified during our inspection. This included infection control practices, safe management of medicines, staff training, standards of care planning and risk assessment, and safe recruitment of staff.
- The provider did not have effective systems or processes in place to enable them to identify, reduce or remove risks to people's health safety and welfare. For example, the lack of robust recruitment and selection processes left people at risk of being supported by unsuitable staff. In addition, systems and processes were not in place to mitigate the risk of fire to people, staff and visitors. The provider completed no formalised audits in relation to fire safety within the service. Most staff had not received fire safety training, fire risk assessments had not been reviewed or updated. We observed some fire doors had been wedged open and missing strips on fire doors. We immediately raised these concerns with the manager who assured they would address these.
- The provider had not established robust systems and processes to enable staff to record and report accidents or incidents, and to ensure these were thoroughly investigated to minimise the risk of reoccurrence and drive improvement in the service.
- Records relating to people's care were not always accurate, up-to-date or complete. People's health appointments and visits were not always recorded fully or accurately. This meant that there was no clear record of when people were seen by health professionals or what the outcome of their appointments or visits were.

The provider's quality assurance systems and processes were not effective and had not enabled them to assess, monitor and improve 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.

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

● The provider had not actively sought the views of people, relatives, staff or visiting professionals on the service and how this might be improved. There were no records of feedback surveys or questionnaires having been sent out by the provider to invite feedback on the service.

● We saw no evidence that staff meetings or meetings with people and their relatives were taking place, to involve them in the service, provide them with key updates and give them an open forum to raise suggestions or concerns. The manager and deputy manager told us they had not held any meetings with people and their relatives since they had been in post.

● Staff felt the manager was approachable and supportive and felt able to raise any concerns about people's care with them. However, not all staff understood whistleblowing or were aware of the provider's related policy. Whistleblowing is the term used when staff report certain types of wrongdoing within an organisation.

● The lack of effective quality assurance systems and processes, audits and regular staff meetings meant management and staff did not have a shared understanding of challenges, concerns and risks in relation to people's care.

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

● We were not assured the provider or manager understood their responsibilities under the duty of candour, or their responsibility to be open and honest with people when care had not gone according to plan. For example, the local authority and CQC had not been informed when allegations of abuse had been made involving people.

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 Care plans and assessments were not personalised to each person using the service. Quality assurance systems and processes did not ensure care plans and risk assessments were reflective of the persons individual needs and wishes.

The enforcement action we took:

We issued the provider with a Notice of Decision to inform them of the areas of concern we had identified. The provider was required to submit an action plan to demonstrate how they had made changes to improve the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the safety and welfare of people using the service.

The enforcement action we took:

We issued the provider with a Notice of Decision to inform them of the areas of concern we had identified. The provider was required to submit an action plan to demonstrate how they had made changes to improve the service.

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 Systems had not been established to assess, monitor and mitigate risks to the safety and welfare of people using the service.

The enforcement action we took:

We issued the provider with a Notice of Decision to inform them of the areas of concern we had identified. The provider was required to submit an action plan to demonstrate how they had made changes to improve the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to operate a robust complaints system. The provider failed to keep a record of these complaints received. There was no evidence of action been taken to resolve the issues or to enable them to monitor for recurring themes to help them improve the service.

The enforcement action we took:

We issued the provider with a Notice of Decision to inform them of the areas of concern we had identified. The provider was required to submit an action plan to demonstrate how they had made changes to improve the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were inadequate. Potential risk and areas of improvement were not identified. The provider had not ensured governance arrangements within the service had been established thus; the provider had failed to identify the concerns we found during the inspection.

The enforcement action we took:

We issued the provider with a Notice of Decision to inform them of the areas of concern we had identified. The provider was required to submit an action plan to demonstrate how they had made changes to improve the service.

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 follow the correct safe recruitment procedures to ensure staff employed were fit to work in the service. They failed to consistently obtain; Criminal record checks, carry out risk assessments for staff working without a DBS, suitable references, identification and assess the skills and competencies of staff employed.

The enforcement action we took:

We issued the provider with a Notice of Decision to inform them of the areas of concern we had identified. The provider was required to submit an action plan to demonstrate how they had made changes to improve the service.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff had received up to date training thus staff did not have the knowledge and skills to support people safely. They also failed to ensure staff were supported by completing regular, supportive supervisions and appraisal.

The enforcement action we took:

We issued the provider with a Notice of Decision to inform them of the areas of concern we had identified. The provider was required to submit an action plan to demonstrate how they had made changes to improve the service.