BNTL Care Ltd

Summerdale Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Summerdale Court Care Home is a care home with nursing. It is registered to provide care and support for up to 110 people in one purpose-built building. However, the provider had closed two of the units and limited their capacity to 58, and at the time of the inspection there were 39 people living at the service. The home had one unit which specialised in supporting people living with dementia. The home also had one nursing unit which provided care to people with nursing care needs. Both units were on the ground floor.

People's experience of using this service and what we found

We identified widespread safety concerns that left people at risk of harm. Risks were not always assessed, identified or reviewed and risk management plans were not always in place to manage risks safely. Care records were not always completed, updated and monitored in line with people's individual needs. Medicines were not always safely managed. Staff were not effectively deployed to keep the home clean and meet people's needs in a timely manner. The environment was unhygienic and poorly maintained. Infection control measures were poor and placed people at risk. Potential safeguarding concerns were not always reported to CQC and learning from accidents and incidents was not disseminated to staff to drive improvements.

Staff did not have up to date training. People were not always supported to eat and drink properly, their personal care needs were not always met, and their dignity and independence was not always considered. There was insufficient information in peoples' care records to support them appropriately with their varying degrees of dementia within the service. People and relatives told us that staff were not always kind and caring. People did not always have end of life care planning in place to identify their end of life preferences. People did not have access to information in ways that would be accessible for them. The provider had not considered people who may have had different communication needs or how to support them. Governance and audit systems were either not in place or were not effective in identifying and reducing risks to people's safety. There was a lack of effective leadership and oversight of the service.

People were not always supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. People had access to healthcare services when required to maintain good health. The provider had a complaints system in place to deal with complaints.

The registered manager had been in post since the beginning of July 2022. The management team had begun to make improvements in the team culture since taking over the service in March 2022, however, these were not yet fully embedded at the service.

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 the service under the previous provider was Requires Improvement, published on 26 January 2021.The new provider registered this service with us on 29 March 2022 and this was their first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the environment, risk assessments medicines, staffing, infection control, cultural needs and the management of the service.

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.

Enforcement
We have identified seven breaches of the Regulations in relation to safe care and treatment, person-centred care, dignity, premises, deployment of staff and good governance.

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
The overall rating for this service is 'Inadequate' and the service therefore is in 'special measures'. This means we will keep the service under review. 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.
Follow up: We will continue to monitor the service closely and discuss ongoing concerns with the local authority. We will continue to monitor the service and if we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Summerdale Court 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 Care Act 2008.

Inspection team
The inspection team consisted of two inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Summerdale Court Care Home 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 had a registered manager who has been in place since July 2022. A registered manager is legally responsible for how a service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. The inspection activity started on 31 August 2022 and ended on 16 September 2022.

What we did before the inspection
We sought feedback from the local authority. We reviewed information we had received about the service. On this occasion the provider was not asked to send a provider information return. This is information

providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection

We spoke with four people who used the service and four relatives about their experience of the care provided. We spoke with six members of staff including care staff, the chef as well as the registered manager and the provider. 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 reviewed records, including the care records of seven people using the service and recruitment files and training records for four staff members. We also looked at records related to the management of the service such as quality audits, medicines, accident and incidents, and policies and procedures. We continued to seek clarification from the provider to validate evidence found. We looked at training data, rotas and medicine documents.

Inadequate

Is the service safe?

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.

Using medicines safely
• Medicines were not always safely managed. People did not always receive their medicines as prescribed which meant they were at risk of harm. During the inspection we found that one person had not been administered their prescribed medicine for a period of eight days and escalated this to the registered manager.
• People who were prescribed topical creams did not have body maps in place to guide staff in relation to where these topical creams needed to be applied. This meant that there was a risk that topical creams were not being administered as prescribed.
• People prescribed transdermal patches which are medicated patches that is placed on the skin to deliver a specific dose of medication through the skin and into the bloodstream. There were no body maps or patch charts in place to ensure that the patches were not administered on the same site as per manufactures guidelines. This meant that there was a risk that people were having transdermal patches applied to the same area of the body when they should be rotated.

• When people were prescribed PRN medicines (this means they took this medicine as and when required) there were no protocols in place to guide staff how and when they should be administered. There were no records describing what these medicines were prescribed for or details such as dose instructions, signs or symptoms about when to offer the medicine. This meant that staff may not have always understood when to give these medicines and that people were at risk of not receiving their medicines as prescribed.

• People's medicines, including PRN were not always recorded on the Medicine Administration Record (MAR). This meant people were at risk of not receiving their prescribed medicines in line with the prescriber's instructions.
• We found that one of the blood glucose testing kit calibration results was out of range. This meant that blood glucose readings taken on that machine were not accurate and people were at risk of harm.

• One person had medicines that required them to avoid eating a specific fruit to be effective. However, this had not been identified until the second day of the inspection. This meant this person had been at the risk of harm. Regular medicine audits were not carried out, but when they were, they failed to pick up the shortfalls we identified in relation to medicines during the inspection.

We found 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 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• People were not protected from risks to their health and wellbeing. Risks to people had not been adequately assessed, identified and managed, which placed them at risk of avoidable harm. For example, there were no risk assessments or guidance for staff in relation to people living with risks such as mobility, behaviour, ability to use call bells, diabetes, choking and stokes.

• People at risk of falls, did not have detailed falls risk management plans in place to guide staff on how to minimise these risks. For example, one person who was at risk of falls did not have detailed guidance on the support they needed to safely mobilise.
• One person was living with Chronic Obstructive Pulmonary disease (COPD) which caused severe breathing difficulties. There was no guidance for staff about how this condition affected the person and what support they required.
• Some people used mobility aids to mobilise, such as a walking frame and wheelchair. Their moving and handling risk assessments which did not identify the potential risks of using these mobility aids. There was no guidance in place for staff on how to safely mobilise the person and how to minimise potential risks. There were also no management plans in place for staff to follow to support people at risk of behaviour that put themselves or others at risk of harm.
• One person's care record showed they were at risk of malnutrition. Their Malnutrition Universal Screening Tool (MUST) recorded that they had lost a significant amount of weight in last three to six months. The MUST had been incorrectly calculated, so, they had not been referred to healthcare professionals as required.

• This person's records showed that they were on a food and fluid chart to record quantitatively all food and drinks consumed as accurately as possible. However, the person's recommended minimum daily fluid intake had not been documented and charts had not been totalled at the end of the day to confirm what the person's fluid intake had been, This meant staff were unable to monitor and take action where poor fluid intake had been noted. Staff we spoke with did not understand why they were completing food and fluid charts. One staff member said, "We complete them so we can tell what food and drinks people like." This placed people at increased risk of malnutrition and dehydration.

• We were not assured that the provider understands fortification strategies that could be used for people who were malnourished or at risk of malnutrition, such as including high-density snacks such yoghurt, milk, nuts and dried fruits.
• Do Not Attempt to Resuscitate (DNAR) forms had been completed for some people, including for one person whose care records showed that they did want to be resuscitated. This was contradictory information, placing them at risk. There were also no hospital passports in place to support people if they needed to attend hospital.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• Following the inspection, the registered manager told us that they had commenced MUST training with staff and that they would speak to people about their food preferences and ensure these were recorded in care plans. We will check this at our next inspection.
• The registered manager told us that they would be checking all DNAR forms to ensure that there was no contradictory information in their care records. We will check this at our next inspection.

Preventing and controlling infection
• Infection prevention control (IPC) was not appropriately managed. The home was unclean, and malodours

were detected in areas of the home. Feedback from relatives said that this was a regular occurrence.
• Floors throughout the home were unclean, including bathroom floors which were wet with tissues on floor. There were remnants of food and drink on some bedroom floors. One relative said, 'The floors are filthy, if there was a broom, I would have swept it myself'. Another relative said, "The cleanliness is awful."

• We saw that laminated cushions on chairs were split or had rips in chair coverings.
• We saw that housekeeping staff did not complete cleaning schedules until the end of the shift, and not as they completed work around the home. The schedules were not checked and signed by senior staff to confirm that the housekeeping carried out was reflected in the cleaning schedules.

The provider failed to ensure that there was an effective system in place to manage infection control. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We observed staff using personal protective equipment (PPE) when supporting people

Staffing and recruitment
• We saw that staff were not deployed to meet people's need effectively and in a timely manner.

• We observed that there was no staff presence in certain areas of the ground floor and people were left unsupervised in lounges.
• Some people told us that staff were not meeting their needs, especially in the mornings or they were kept waiting for long periods of time for support. One person said, "Breakfast is often late, today it was at 9.15 for example. I would like to eat at 8am." Another person told us that they need two staff to support them in the morning and liked to get up around 10am, so they could take part in the morning activities. However, staff were not always able to get them up in time. The person told us, "Sometimes it can be as late as midday and by which time the morning activity is over."
• Relatives told us that staff rushed when supporting people. One relative said, "Staff are rushed of their feet. My [relative] is stuck in bed all the time." Another relative said, "They could do with more staff…"

• Some staff we spoke to told us that they felt that there were not enough staff, therefore they were not always able to complete all the tasks expected of them, this was namely reviewing and updating care records. One relative told us, "My [relative] likes a chat, but staff don't have the time to speak to them.".

The above issues with staffing amount to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff recruitment records showed relevant checks had been completed before staff began working unsupervised at the service. We saw completed application forms, proof of identity, relevant professional registration numbers, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records.

Systems and processes to safeguard people from the risk of abuse. Learning lessons when things go wrong
• People were not always protected from the risk of abuse. Some relatives told us they did not always feel people were always safe. One relative said, "My [relative] has to be somewhere because they can't be at home. I would move them if I could." Another relative said, "Staff leave hot cups of tea on the side of my [relative's] bed who is bed bound and could get burnt. Staff should put the tea in a beaker, I have told them, but they don't listen."
• The lack of clear and accurate guidance for staff of how to safely meet people's needs placed people at the risk of unintentional harm.

• We found that the provider had not always referred incidents to either safeguarding authorities and/or CQC. The incidents included potential abuse, such as unexplained bruising to people.

• The provider failed to record accidents and incidents prior to August 2022 and failed to disseminate learning from accidents and incidents to staff.
• The registered manager told us that staff did not always escalate concerns to them, hence the reason why safeguarding teams and CQC were not always notified. They said that they would ensure that staff had refresher training in relation to safeguarding and understood the process to escalate concerns. We will check this at our next inspection.

The above issues regarding the provider's systems about protecting people from the risk of abuse amount to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

• There was no system in place to show that staff training was regularly reviewed and up to date. The provider had set up a new e-learning system that was not fully operational. It showed that staff trained in Moving and Handling was 0%, IPC was 4.5%, COSHH was 4.6%, Health and Safety was 6.1%, Dementia Care was 6.1% and Fire Safety was 9.1%. These identified shortfalls in training meant that provider could not be assured that staff had the right skills and knowledge to meet people's needs properly and safely.

• There was no system in place to assess staff knowledge of training delivered when the service was run by the previous provider.

• Some relatives told us that they did not feel staff were well trained. One relative said this was because staff did not seem to be aware of their relative's health conditions and that they caused their [relative] pain when they supported them. Another relative said, "Only some staff are well trained."

The above issues amount to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff told us they received regular supervisions since the new registered manager came into post. To ensure that this is embedded into the culture of the service. We will check this at our next inspection.

Adapting service, design, decoration to meet people's needs
• The environment was not safe, or well-maintained. We saw that the home overall needed redecoration.

• Not all fire doors were fit for purpose. For example, fire doors in communal areas did not close flush with each other. We saw the bottom of one bedroom's fire door had a big gap. This meant that these fire doors would not keep people safe in an emergency.
• One handrail in a communal area was loose at one end, and a plastic light cord in one communal bathroom had the cord handle missing, which could make it unsafe for people. Carpets were held together by gaffer tape in places.
• There was some signage in places but not throughout the home. Not all people's bedrooms had their

names, photographs, door number or memory boxes in place. These issues meant people may not be able to orientate easily around the home. The registered manager told us that they were working on ensuring all bedrooms were easily identifiable. We will check this at our next inspection.

The premises and equipment were not clean, secure, or properly maintained. This placed people at risk of harm. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People's bedrooms were personalised, with photographs and items that were important to them.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The provider had failed to reassess the needs of everyone living at the service since they took over the home at the end of March 2022 or actively involved people or their relatives in making decisions about the care, support and treatment that they received.
• The provider had relied on care records from the old provider. This meant that the provider could not be assured that people's care records were up to date and support needs had not changed.

• The majority of people living at Summerdale Court were living with dementia ranging from early onset to advanced stages. Their care plans were not person-centred or reflective of best practice or evidence-based guidance for dementia care to ensure effective outcomes were achieved.

This was a breach of Regulation 9 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 supported to have enough to eat and drink. People were given a choice of meals, and staff physically showed the meals on offer to people so that they can make a choice at the time.

• We observed staff interacting positively with people and the atmosphere was present and relaxed.
Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The provider worked in partnership with other agencies to ensure people got access to healthcare services.
• A GP regularly visited the service and since the new registered manager came into post were providing a written report about people health to assist staff.
• Healthcare visits from district nurses or chiropodists were recorded in people's care records.

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

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

We checked whether the service was working within the principles of the MCA.

• We found the service was working within the principles of the MCA and appropriate legal authorisations were in place to deprive a person of their liberty.
• The manager had an understanding of the MCA and when it should be applied. People were encouraged to make all decisions for themselves where they could.
• Records confirmed capacity assessments had been completed and people and those important to them were involved in best interest meetings.
• People's rights were protected because staff sought their consent before supporting them.

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 of this newly registered service. At this inspection this key question was rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
• People's privacy, dignity and independence was not always respected. Relatives told us that staff did not treat people with respect and dignity. One relative said, "My [relative] is not always dressed in fresh clothes every day, they are in clothes from the day before. My [relative's] nails overgrown and dirty and [staff] don't clean their teeth, they look awful." Another relative said, "I have found my [relative's] hair matted and can smell a malodour coming from them. I told staff, things improved for a few days and now it's gone back to what it was. People should be treated with dignity…. there is no dignity." A third relative said, "Staff leave plates of food on my [relative's] bed and they end up eating food with their hands."

• During the inspection we saw that some people in bed, had their bedroom doors open and their legs were exposed. This meant that people's privacy and dignity was not maintained.
• Care records did not clearly detail what people could and could not do for themselves or give staff specific guidance on how to support people to maintain their independence.
• We saw that people's records which included daily notes, food and fluid charts, bed rail checks, topical cream application and stool charts were not securely stored but left sitting on top of counter at nursing station. This meant that people's confidential information was and accessible to anyone who might pass. People were not treated with dignity and respect; their privacy was not maintained, and they were not involved in making decisions about their care.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensuring people are well treated and supported; respecting equality and diversity. Supporting people to express their views and be involved in making decisions about their care
• Issues with the training, along with lack of management oversight meant improvements were needed to ensure people were well cared for and received a good standard of care.
• We received mixed views from people and relatives about how kind and caring staff were. One person told us, "Staff are very caring." One relative said, "Staff come across as rude and abrupt, it could be cultural the way they speak." Another relative said, "Even if staff see you, they ignore you."
• People were not actively involved in making decisions about the daily care they received. No evidence was available to show people, or their relatives had input into their care plans or were consulted on daily decisions surrounding their care.
• Records showed that the provider had not explored the support people needed to maintain their faith and

appropriate support was offered to people.
• People's views were not captured in their care plans about how to give people choices during personal care. For example, whether they preferred to have a bath or shower and how often. These issues required improvement.

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 of this newly registered service. At this inspection this key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences.
• People were not always given a choice and control to meet their needs. Care plans were not person centred and did not provide staff with the information they needed to ensure people received person-centred care and treatment appropriate to their needs. For example, one person told us they would prefer food in accordance with their religion, but this had not been offered.
• Some relatives told us that people were not always offered the foods they enjoyed. One relative said, "My [relative] has lost weight because they don't like the food and staff don't know what their likes are." Another relative said. "The standard of food is not good, there is a mismatch of food, I bring food in myself for my [relative]."
• Some relatives told us that they felt that their relatives were unable to eat without support. Although the told staff about this, they felt unheard. One relative said, "[Staff] say my [relative] can eat by themself – but when I go down, I feed them". Another relative said, "My [relative] cannot eat without help, they really can't. Staff say my relative can feed themselves, they don't listen when I tell them they can't."

• People and relatives told us that they were not involved in the planning of their care. People's care plans did not document that they or their relatives had been involved in their care planning. One person said, "I am not involved with my care plan." One relative said, "I have not been asked about my [relative's] care plan, I have given up on this." Another relative said, "I have not been involved in my [relative's] care planning.

• Care plans did not address the different stages of peoples' dementia and how this affected their daily lives in terms of their wellbeing and independence.
• Relevant and important information to guide staff on delivering individual and responsive support to people was missing. For example, there was no detailed guidance for staff on the reasons why some people may become anxious or agitated, or the triggers that might intensify their anxiety. There was no guidance for staff on the strategies to positively engage or distract people.
• Records of care did not always demonstrate that people's preferences were respected. For example, one person's care plan did not detail information about their dietary preferences which linked to their cultural background.
• Care plans were not regularly reviewed and failed to reflect changes in people's health and wellbeing. For example, one person had been in hospital for a couple of weeks, however, on their return their care plan had not been updated to reflect the changes in the care needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.
• People were not always supported to engage in activities which were socially relevant to them. We saw that the activities board was displayed in the foyer of the service, where people were unable to view it.
• The service employed two activity coordinators during the weekdays. However, we saw that meaningful activities were not always provided to people.
• In the morning on the first day of the inspection, the activity advertised was doing puzzles, however one activity coordinator told us that they had decided not to carry out the scheduled activity as they were going to carry out one to one sessions with people. The coordinator said that they aimed to see each person in a one-to-one session for about 10 minutes.

• In the afternoon on the first day of the inspection, the advertised activity was hand massages, but we observed some people watching a film about World War II aeroplanes. Failing to carry out scheduled activities could disorientate people and people were not getting the stimulation they required, especially if they were cared for in bed.
• We saw people were seated in two separate lounges, the activities we observed only took place in one lounge. In the other lounge people were seated in front of a television during the day on both days of the inspection.
• Care plans lacked information about people's interests, social activity and stimulation.
• We spoke to relatives about the activities on offer. One relative told us, "I don't know that my [relative] does any activities. Another relative said, "My [relative] is stuck in bed, staff don't talk to them… my [relative] is quite isolated. They are not moved from their bed and not encouraged to join in activities."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• People's communication needs were not always clearly documented in their care plans, and they were not offered information in a format that met their personal needs. Such as large font or in a pictorial format.
• Care plans did not always contain guidance for staff on how to communicate with people with different communication needs. For example, if staff should maintain eye contact, keeping sentences short, or if people needed any listening or visual aids.
• Where one person's first language was not English, their care plan documented that staff relied on the person's relative to translate or that staff used gestures to communicate with the person. However, there was no guidance for staff on the gestures that they needed to use, and other methods of communication had not been explored.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
• The registered manager confirmed that they were not providing end of life support to anyone at the time of our inspection. However, people's care records did not document people's end of life preferences and wishes.

• The registered manager told us that they would meet with people and their relatives to discuss their end of life wishes should they be needed. We will check this at our next inspection.

Improving care quality in response to complaints or concerns
• The provider had a system in place to handle complaints effectively in line with the provider's complaints procedure. Relatives told us they knew how to complain One relative said, "I have made a complaint and it was dealt with."
• The registered manager maintained a log of any complaints made about the service, which had been addressed in line with the provider's complaints procedure.

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 of this newly registered service. At this inspection 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; 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; Continuous learning and improving care
• The provider had failed to ensure they operated effective systems to assess and improve the care provided. This meant the provider was not able to effectively identify issues that we found at the inspection.

• The provider had a lack of effective leadership, governance and oversight of the service. The provider failed to ensure there was effective scrutiny at senior management level. This meant people were exposed to unsafe care and treatment.
• Risks in areas including mobility, behaviour, ability to use call bells, diabetes, chronic obstructive pulmonary disease choking and stokes had not been identified as areas which needed to be addressed by the provider's quality assurance systems.

• The provider had failed to carry out regular audits to identify issues. For example, there were no audits in relation to care plans, infection control, falls, accident and incidents, therefore issues we found at this inspection were not identified until the inspection.
• The provider had failed to ensure that staff were deployed to meet people needs in a timely manner and keep the home clean throughout.
• The provider had failed to ensure that the home was well maintained, in a good state of repair and safe for people to live in.
• After the inspection we asked the provider to implement improvements to ensure people were protected from the risk of harm. They responded with an action plan about managing and making improvements but failed to give completion dates for the improvements needed. This meant we could not be assured when the improvements would be made by.
• The provider had failed to ensure they always met the duty of candour. During this inspection we alerted the provider to cases of unexplained injuries and people at risk of harm and medicines error. These had not identified this before. After the inspection the manager completed informed both safeguarding team and CQC of these incidents.

The provider had failed to ensure systems for governance and management oversight were robust, safe and effective. This placed people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014

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• The registered manager had been in post since the beginning of July 2022, and we were assured that they knew the scale of the challenge ahead of them.
• Following the provider committed to carrying out a deep clean of the home. We will check this at our next inspection.

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; Working in partnership with others.
• Relatives told us the service was not well-led. One relative said," Staff need to have better communication with relatives." Another relative said, "There is no communication with management."
• The provider did not promote an open and inclusive service. Some staff told us they did not always feel supported by management and there was a high level of expectation from the provider that was not achievable.
• Some relatives told us that the provider had held one meeting since they took over, however they had not been able to attend. One relative said, "I was invited to a meeting in March 2022, but couldn't make it. I have not heard from them since."
• There were no records to show that recent failures identified by the local authority had been shared with staff and that they were involved in proposing new ways of working or improvements.

The provider had failed to ensure systems for governance and management oversight were robust, safe and effective. This placed people at risk of harm. This was a
breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

• Following the inspection, the provider told us that they will be formally engaging with relatives. We will check this at our next inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was not always respected

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from the risk of abuse

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises was not safe or well-maintained

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not effectively deployed to meet people's needs in a timely manner or to keep the home clean

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 Peopel were not receiving person centred care as their wishes had not been assessed and the care delivered did not reflect their preferences. Regulation 9.

The enforcement action we took:

we issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not been assessed or appropriately mitigated. Regulation 12(1)

The enforcement action we took:

we issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not operated effectively to monitor and improve the quality and safety of the service. Regulation 17

The enforcement action we took:

we issued a warning notice