U.K. International Nursing Agency Ltd

UK International Nursing Agency Limited Dom Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
UK International Nursing Agency Limited Dom Care is registered to provide accommodation for up to seven people who may require nursing and/or personal care. It is also registered to provide personal care to people living in their own homes. During this inspection there were five people accommodated at the care home with nobody in receipt of personal care in the community.

The home offers accommodation on two floors. The home had dining and communal living space for people to spend time together. Some bedrooms had en-suite facilities, with shared bathroom and toilets also available for people.

People's experience of using this service and what we found
People were not protected from abuse. Staff's knowledge about safeguarding was poor and the registered manager and provider failed to recognise and report safeguarding concerns. Protection plans for people were not implemented and they were left at risk of further abuse. There were not enough skilled staff deployed to meet people's needs safely and effectively.

Fire risk concerns that the registered manager and the provider were made aware about by fire safety specialists had not prompted them to reassess the level of risk people were exposed to in case of a fire. The level of risk to people's health and safety from living in an unsafe environment with clutter, trailing wires and poor infection control procedures were not assessed or mitigated. Risk assessments in place for identified health needs had insufficient guidance for staff to know how to lower the risk and help keep people safe.

People were not supported to have maximum choice and control of their lives. Staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support best practice. People had numerous restrictions applied to their freedom. The registered manager and the provider imposed these restrictions without having the legal authority to do so. People were cared for in bed, not supported to go out in the garden or the community. In addition, they were denied the use of their own phones, computers and denied help with on-line shopping if their behaviour was considered inappropriate by the registered manager or the provider.

People's needs were not met at the service. The registered manager and the provider had failed to implement rehabilitation guidance people were given when discharged from hospital. People's needs were not reviewed and, except for the GP, specialist external health professionals' input into people's care was not requested.

Staff were not trained to understand and meet people's needs. Staff received "all-in-one" training consisting in 13 subjects delivered in one day. Training for staff to understand people's mental health needs or behaviour support had not been given. Staff's competence or understanding of their training was not assessed. The registered manager and the provider failed to ensure people received a varied and nutritious

diet.

People had limited involvement in their care and support. The lack of skills staff had, and the culture promoted by the leadership in the service, prevented staff from supporting people in a kind and compassionate way. We observed that staff were respectful when talking to people. However, the language and terminology used by management when talking about people and language used in people's care plans evidenced a labelling, discriminative approach towards people with protected characteristics. Independent advocate support had not been requested by management for people who had limited involvement from someone close to them to act as their voice.

The care and support people received was routine led, based and centred around their basic needs only. People received their personal care, food, drinks and were kept warm. For most people living in the home, the time staff were supporting them with these needs was the only interaction they had during the day. Staff were overstretched and completing task like meal preparation, housekeeping and supporting people with their care needs. This meant that they had limited or no time to organise meaningful activities, support people to go out or spend time chatting to people. People's end of life care wishes were not recorded or explored at a time when they could voice their opinions, therefore the plans in place for any future care needs were not personalised.

The registered manager and the provider failed to comply with the legislation and regulatory requirements set out by the Care Quality Commission (CQC) at the time when they registered. They had failed to notify CQC of significant events requiring such notifications. They had admitted people to the service, without notifying CQC that the individual's needs did not fall under their initial registration and they had failed to register their kitchen with the appropriate agency who regulates food safety and preparation.

The registered manager and the provider neglected their management duties and worked as part of the staff team as nurses. This had a negative impact on the management and oversight of the service and led to poor governance systems, lack of meaningful quality assurance processes and any audits being carried out. They failed to promote a positive culture amongst the staff team and failed to keep up to date with current best practice, legislation and regulatory requirements. This had a negative impact on people from being supported by a staff team who lacked skills and understanding of safe, effective and personalised care practices.

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

Whilst there were no people with a learning disability or autistic people living in the home, there is an expectation that providers and registered managers who are registered to offer this service be knowledgeable and understand best practice. The management in the home were not knowledgeable about current best practice and guidance. Neither the registered manager nor the provider recognised the signs of their service operating a closed culture. They provided a service to people without external health and social care professionals input, failed to have an open and transparent approach or effective communication with external agencies or listen to the voice of the people using 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
The last rating for this service was good (published 14 October 2017).

Why we inspected
This inspection was prompted by a review of the information we held about this 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 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 safeguarding people from abuse, safe care, staffing, consent to care, personalised care and management processes.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service 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 time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

UK International Nursing Agency Limited Dom Care

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was carried out by two inspectors.

Service and service type
UK International Nursing Agency Limited Dom Care is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. UK International Nursing Agency Limited Dom Care is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is also registered as a domiciliary care agency. It provides personal care to people living in their own houses and flats. There was nobody using the service at present.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally

responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started 18 May 2022 and ended on 28 June 2022. We visited the home on 18 May 2022 and 28 June 2022.

What we did before the inspection
We used information gathered as part of monitoring activity that took place on 25 April 2022 to help plan the inspection and inform our judgements. We reviewed information we had received about the service since the last inspection. We sought feedback from professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. 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 three people who used the service and one relative about their experience of the care provided. We spent time observing two other people who could not talk to us. We spoke with three members of staff and the registered manager.

We reviewed a range of records. This included four people's care records, medication records and daily notes. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 met with social care professionals to seek their feedback about the service.

Inadequate

Is the service safe?

Our findings

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

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

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

- The registered manager was not aware what lessons learnt process was. They had not identified any areas in the service where lessons learnt could have had a positive impact in improving people's experience of the care they received.
- People were not protected from the risk of abuse. One person told us, "I don't belong here. I am not happy or safe here." Staff we spoke with and the registered manager did not demonstrate a good understanding of safeguarding processes. Staff told us they reported their concerns to the registered manager and the provider, however these concerns were then not investigated or reported to safeguarding authorities or CQC.
- One person sustained an injury to their arm and neck. The registered manager told us the person had not hit their arm, however they could not establish how the injury happened. Although they knew that some staff had not received manual handling training and some staff training had lapsed, they had not considered that the injury could have been related to how staff supported the person to move. Staff were not observed for competency in safely moving and transferring people. The registered manager had not reported this incident to local safeguarding authorities or CQC. The person's relatives raised this with the safeguarding authority, and it was under investigation at the time of the inspection.
- People were subjected to a multitude of restrictions applied to their freedom. For example, three people were cared for mainly in bed in their bedroom without a clear reason as to why. For example, one person had been out of bed five times between February 2022 and 28 June 2022.
- People with protected characteristics were discriminated against by being subjected to a series of restrictions imposed by the registered manager and provider because they had behaviours considered "undesirable" (quote from the person's support plan) by them. For example, staff had not followed a person's rehabilitation plan and were not supporting them out of bed because they could not support this person's anxiety and ways of expressing themselves. Another person had their phone and computer locked away and they were denied access to these. They were also denied support to go out and help with their on-line shopping if the registered manager or provider considered that their behaviour did not warrant these "privileges" (quote from the person's support plan).
- One person told us they had no choice but sign that they agreed to restrictions because the registered manager told them they either agree or they would apply for a Deprivation of Liberty Safeguards (DoLS) authorisation. The person had been misled and coerced in signing the care plan unaware that DoLS authorisations were granted through a process which included assessing people's capacity.

The provider and the registered manager failed to operate effective safeguarding processes, and this left people at risk of abuse. They promoted a discriminative approach towards people with protected characteristics. People were subjected to unlawful restrictions and control over their freedom. This was a

breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person told us, "I am safe here. I stay in bed and I feel safe with staff." A relative told us they felt staff made efforts to keep their family member as safe as possible.

Assessing risk, safety monitoring and management

● People were exposed to risk in case of a fire. The registered manager and the provider failed to ensure recommendations made by external fire risk assessors were actioned. On 05 July 2019 the fire risk assessment completed by an external fire assessor recommended that staff were trained and practiced horizontal and vertical fire evacuation. The registered manager failed to ensure this happened. There were two fire drills carried out from 2019 to 2021 and these included two individual staff members, the registered manager and the provider. This meant six staff working in the home had not had any practical training in evacuation.

● On 24 April 2022 a fire reform order had been issued by the local fire service against the provider for failing to review the fire risk assessment since 2019 and concerns about the fire doors not withholding a fire for at least 30 minutes. In response, the provider had an external fire risk assessor carrying out a fire risk assessment on 10 June 2022. The assessor deemed all fire doors as not meeting current standards and needing to be replaced. The registered manager and the provider failed to robustly assess the level of risk people were exposed to in case of a fire and the actions required to lower the risk until the fire doors could be replaced.

● People were not safe from the risks of food-borne illnesses. The registered manager and staff were responsible to prepare meals for people in the home. We found that some staff involved in food preparation had not received training or their basic food safety training had lapsed. On 19 May 2022 an Environmental Health Officer (EHO) carried out an inspection in the home to assess if the food and drink staff provided to people was handled, stored, prepared and delivered in a way that met the requirements of the Food Safety Act 1990. They found numerous failings in the registered manager and staff's practices. For example, numerous food items being stored on the floor or in a mouldy storage area, appliances and work surfaces were not clean and no records of food temperatures were kept. This meant the registered manager and staff were not knowledgeable about safe food practices and this put people at risk of harm.

● Risk to people's health and safety were not assessed or mitigated when they lived in an unsafe environment. For example, in a person's bedroom there were trailing wires on the floor, clutter and used body wipes on the floor. The registered manager told us this was the person's choice, however they failed to assess the risk to the person and others living in the home and show how they had discussed this with the person and supported their understanding of living in a safe environment.

● Risk assessments in place were not detailed enough to give staff guidance on how to lower risk. For example, mobility, falls, choking risk assessments needed more information as to what equipment staff needed and how to use this equipment safely.

The provider and the registered manager failed to assess and mitigate risk to people's health and safety. People were placed 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

● There were not enough staff deployed to meet people's needs. The registered manager told us they based their staffing level on occupancy which meant they have not taken in consideration people's needs.

● People's needs were not met because of the lack of staff. For example, the care plan for one person indicated that when they were distressed one to one support was needed. This had not been factored in the

staffing numbers. We heard the person constantly calling out, shouting from their bedroom for staff attention on both days when we visited. Staff attended to them to remind them to keep quiet. They did not spend time with the person.

● People were not supported to go out in the community and were cared for in bed without an obvious reason. Staff were busy with supporting people with personal care, housekeeping and meal preparation duties. For example, a person requested staff's support to go to church. They were refused because the staff member was preparing meals.

● Staff rotas evidenced, and the registered manager confirmed, that at times only one staff member was working during the night with another staff on sleeping duty in case of an emergency. This meant that four people who required assistance of two staff members to have their needs met were not supported in line with their care plan and needs through the night. This put people at risk of harm.

The lack of staff to meet people's needs was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had processes in place to recruit staff safely in line with legislation.

Preventing and controlling infection

● People were not protected from the risk of infections. On both days of our visits we had to share our concerns with the registered manager about staff and contractors not wearing masks whilst in the home in accordance with current guidance.

● Cleaning schedules were signed daily by staff to indicate that they deep cleaned the bedrooms, the kitchen, dining room, and shampooed the carpet on the corridor every day. We observed the dining room and the kitchen on our first day of inspection being cluttered and items stored on the side boards on the floor. Observed dust and stained carpet on the corridor upstairs and the stairs. We noted that on the first and second day of our visit we had not observed any cleaning procedures in the home. On the first day we had to report to EHO due to the clutter and unhygienic state we found in the kitchen. Cleaning schedules were signed that the kitchen had been deep cleaned a day before our visit. Therefore, we consider the cleaning schedules are not reliable evidence to support good infection control measures.

The lack of effective infection control procedures, and failing to provide a clean and safe environment for people to be safe from the risk of infections was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People had their medicines given to them by nursing staff. However, the registered manager and the provider failed to ensure nursing staff had their competencies to administer medicines assessed regularly. The registered manager had not had any medicine administration training since 2017 and the provider had no record of completing medicine administration training.

● Medicine administration records (MAR) were completed and signed by staff after they administered people's medicines and they recorded if people refused these. However, the reason for refusals were not recorded to ensure when medicine reviews took place these could be analysed.

● We randomly selected and counted medicines for three people. The counts corresponded with records kept except for one tablet. We asked the registered manager to re-check and count to ensure there were no errors made.

Inadequate

Is the service effective?

Our findings

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

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People's needs were not met at the service. The registered manager completed a pre-admission assessment for people before moving in. However, we found that these assessments often were incomplete and lacked personalised information.
- People living in the home had a wide range of varying needs. The registered manager admitted people with physical disabilities, sensory impairments, living with dementia, mental health needs and stroke without clear plans on how to meet people's various needs. For example, a person had been in rehabilitation following a stroke. They were discharged to their own home but moved to the service after a few weeks. The registered manager failed to implement the rehabilitation plan recommended by health professionals and ensure staff followed this. This put the person at risk of poor health.
- The registered manager and staff were unable to demonstrate knowledge and understanding of current guidance and recommended best practice when supporting people with mental health conditions. For example, the registered manager completed a Care Programme Approach (CPA) 01 May 2022 care plan for a person. The plan was solely managed by them, the provider and staff, without any input from specialist mental health services. This approach had been stopped by NHS in 2021 specifically due to the lack of multidisciplinary approach this plan consisted of.
- The registered manager and the provider failed to involve relevant health professionals in people's care. For example, a person had only bed baths. The registered manager told us they could not support this person to have a bath or a shower because they required a specialist shower trolley. They failed to request involvement from an occupational health therapist to source the needed equipment.
- People's needs were not effectively reviewed. The registered manager recorded in people's care plans every month that they have reviewed the care plans, however we found incidents and events where input from other professionals like mental health specialists, behaviour support specialists, physiotherapists could have benefitted people and this had not been requested.

Failing to meet people's needs and seek professional input to maximise people's health and well-being was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff were not trained and lacked skills and knowledge to meet people's needs effectively. Not receiving

the support needed people were placed at risk of deterioration of their physical and mental health.
● The training staff received were basic 'all-in-one' sessions. This meant that staff attended a one-day training session where they were given training in 13 different subjects. Staff told us this was mainly theory. One staff member said, "The training is all-in-one. Its theory mainly, we do practice resuscitation."
● Staff lacked understanding of people's needs and their responsibilities. One staff member told us safeguarding meant they had to "keep a close eye" on people who could physically hurt them. Staff had no understanding of how to effectively support people living with mental health needs to stay well. One staff member told us they could not support a person with this need at times because the person made allegations about them later. They could not tell us what positive support strategies they used to enable the person to feel well and enjoy their life.
● Staff had no training to understand best practice when supporting people following a stroke, with sensory impairments, mental health or dementia training. This had a significant impact on people. For example, people were not supported to leave their bedroom or come out of bed.

The lack of suitably qualified, competent, skilled and experienced staff to meet people's needs was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People's consent was not always sought in line with the law. The provider had CCTV fitted in corridors and communal areas without asking for people or their rightful representative's consent.
● People's consent for the support they received had not been sought or recorded.
● The registered manager and the provider failed to ensure they followed the MCA principles when assessing people's capacity and that decisions to apply restrictions on people's freedom were made through a best interest process involving professionals as well as people's representatives.
● The registered manager and staff had a poor understanding of the Act and when DoLS were applicable. For example, the registered manager assessed a person as having capacity, however they still applied restrictions on this person's freedom without consent.

The lack of appropriate processes to seek people's consent for the care they received was a breach of Regulation 11 (Need for consent) 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 supported to have a nutritious and balanced diet. People's dietary needs required for the conditions they lived with were not met. For example, the NHS issued guidelines on dietary

recommendations for people who had (a specific medical condition). The registered manager and the provider failed to discuss this with a person living with this condition and failed to ensure staff were trained to meet this person's needs.

● One person told us they were happy with the food provided to them and another person told us the food was not of a good quality and they had limited choices available.

● People had limited choices and often were provided with frozen ready-made meals and the same meal cooked every Tuesday and re-heated on Wednesday. One staff member told us, "I tried all the frozen [type of meal] and found that in [supermarket chain] is the best one."

● The registered manager and the provider failed to ensure they developed a varied nutritious menu for people, to include their food preferences and enough choices for people.

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

● The service was not fit for purpose in line with statutory requirements. For example, we found deficiencies with fire safety, food preparation areas and building condition concerns that were reported to the appropriate organisations.

● Health and safety risks of the premises (including grounds) and equipment were not regularly assessed or reviewed. This meant that improvements needed could not be acted upon without delay as these were not identified by the registered manager, provider or staff.

● The physical environment had not been adapted to take into consideration the needs of people living with dementia. For example, there was a lack of signage to support people to navigate around the home. This meant people could not easily orientate themselves within the home. There were no interactive or dementia-friendly resources used within the home. The provider had no meaningful programme of activities for people to engage with.

Inadequate

Is the service caring?

Our findings

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

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

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

- One person told us that staff were kind and they were happy with the support they received. Another person told us that they felt at times intimidated by some staff, they were not listened and were not happy with the support.
- People had limited involvement in their care and support. The lack of skills staff had, and the culture promoted by the leadership in the service prevented them from supporting people in a kind and compassionate way. We observed that in general staff were respectful when talking to people. On one occasion we overheard one staff member raising their voice and in a harsh tone asking a person to keep quiet and not to shout anymore.
- Whilst some people's likes and dislikes were promoted in some instances, this had an impact on others. For example, when meals were prepared for two people from the same cultural background, everyone else in the home had been given the same meal not considering their individual preferences.
- Independent advocate support had not been requested by management for people who could not be involved or lacked confidence to be involved in decisions about their care.

The lack of personalised support people received was a further breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

- The language and terminology used by management when talking about people and the language used in people's care plans did not promote people's dignity. Care plans evidenced a labelling, discriminative approach towards people with protected characteristics. For example, terms used were "these people" (when referring to people with mental health and behaviour support needs), "telling lies", "[Person] looks bizarre".
- People were supported by staff who had no guidance and understanding of how to promote people's independence, maximise their involvement in the support they received and achieve positive outcomes. For example, prior to moving in the home a person was working towards and looking forward to being able to make themselves a cup of tea and being able to use some of their cooking and baking skills again. They were not supported with their rehabilitation exercises to achieve this.

The lack of dignifying support people received was a further breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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 received care and support which did not take account of their likes, dislikes and preferences. The care and support centred around staff routine and availability and not around meeting people's needs in a personalised way. For example, people were not asked what time they wanted to get up in the morning or go to bed, if they wanted to spend time in their bed, bedroom or in the garden and they were not asked about their preference of gender of staff supporting them with personal care.
- Care plans in place were task led and did not include guidance or information for staff to provide person centred care.
- People supported in bed were at risk of social isolation. Some people hardly left their bedroom since they moved in the home. There was no time allocated for staff to engage and spend quality time with people. One staff member said, "We spend time with them chatting when we do personal care or help them eat."
- One person told us they enjoyed quizzes; however, these were not organised often. As a result, they chose to stay in their own room and listen to the radio. People's abilities and hobbies were not considered on the rare occasion when staff organised activities. For example, one staff member told us they liked organising arts and craft activities for people when they had time, however some people in the home had physical disabilities which prevented them from actively being involved in these sessions.
- People had not been supported to go out and engage in the local community. There were no trips, entertainment or other opportunities for people to spend their time without boredom.

The lack of reasonable adjustments for people to receive care and support in a person-centred way and lack of engagement opportunities provided was a further breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- People had no individual communication plans that detailed effective and preferred methods of communication, including the approach to use for different situations.
- We observed how people communicated with staff and found that staff understood people, however,

there was no information available as to what people's preferences were when staff had to provide them with information. For example, two people living in the home were blind. Staff told us they were giving people information verbally, however, they were not involved in their care planning, or in important decisions about their care.

Improving care quality in response to complaints or concerns

● One person told us they were not listened and therefore there was no point for them to complain. One complaint had been recorded by the registered manager in April 2022. However, they have failed to acknowledge or respond to the complaint in line with the providers complaints policy. They told us the concerns raised in the complaint were investigated by the local safeguarding authority and this was the reason they had not responded.

● Complaints or concerns from people were not used to improve the service and people's experience of the care they received.

End of life care and support

● At the time of the inspection nobody was receiving end of life support. However, this support has been detailed as available for people who lived in the home.

● People were not involved in planning for the future and what they considered important when they were nearing the end of their life.

● Staff had no training to understand best practice and current requirements and expectations when supporting people nearing the end of their life.

Inadequate

Is the service well-led?

Our findings

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

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

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 and registered manager acknowledged things had gone wrong, and apologies were given at the time of our inspection. People, relatives or staff, however, were not informed of the actions CQC were taking following this inspection. We asked the registered manager to report the concerns we found to the authorities funding people's care. They failed to do this. We alerted the funding authorities of the concerns we found.
- Where incidents occurred within the service, we did not see evidence of how this was investigated, reported and apologies given when things went wrong. We found a closed approach from a provider and registered manager who blamed others when things went wrong and did not act in an open manner to accept their responsibility to improve the lives of people using the service.
- We identified several examples where records gave a differing version to what we were told by the registered manager. For example, we asked if staff slept in the service at night. We were told they did not by the registered manager. When we looked at staff rota's we found staff did sleep in at night, and the registered manager admitted this to us.
- The provider had not operated robust systems to enable staff to learn from incidents and improve through professional reflective practise. This undermined staff's ability to minimise the risk of recurrence and drive improvement in the service through shared learning.

The registered manager had not acted in an open and transparent way with either people using the service or with CQC. This was a breach of Regulation 20 (Duty of Candour) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The service operated a closed culture that exposed people to the risk of harm. A closed culture is a poor culture in a care service that increases the risk of harm. This includes abuse and human rights breaches. We have identified throughout this report where people suffered harm, or their human rights were infringed.
- Care plans did not always reflect people's needs as information was incomplete and not always accurate. This had a negative effect on the delivery of person-centred care. Risks that affected people and others were not properly assessed to reduce the risk of recurrence.
- The registered manager and provider used labelling language when talking about people with protected

characteristics and developed care plans to guide staff in imposing significant restrictions on people and therefore a breach of their human rights. This led to a judgemental and punitive culture where people's needs were not met safely.

● Systems were in place to monitor the safety of the care provided but were ineffective as they were not used. The registered manager told us they failed to regularly audit key areas, like infection control, care records, fire risk assessments. They told us they completed an annual assessment of all areas of the service. The last annual assessment was completed in March 2022. This assessed areas such as the environment, food safety, consent, fire safety, care planning and people's general care and support. In every section of the audit, the registered manager scored themselves one hundred percent identifying no areas for improvement. This was a failure to identify and manage risks posed to the health, welfare and safety of people and complete a robust audit process.

● There was a lack of understanding among the management team about the Mental Capacity Act 2005, and the importance of ensuring people who lacked capacity were empowered to make decisions about their care. Nationally recognised evidence-based guidance was not used when delivering and reviewing care, for example in supporting people with dementia or mental health needs.

● The systemic failings outlined in this report demonstrated the provider had failed to ensure people received a well-managed service which was safe and compassionate, placing people at risk of potential harm.

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.

● CQC had not always received notifications about safeguarding incidents at the service. The registered manager is responsible for telling CQC about incidents such as injuries or safeguarding concerns that occur at the service. This meant opportunities to monitor and review the service were not always in place.

The failure to submit notifications as required was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

● People's feedback about the running of the service had not been sought. The registered manager had not sought appropriate ways to gain this feedback by giving people information in a way they could understand.

● Meetings were not held with people or their relatives. Staff meetings had not been regular and where these were held staff were not involved. There was not an open forum to raise suggestions or concerns, receive updates on the management of the service or share meaningful information.

● We received mixed feedback from people about the quality of the service. One person felt threatened and bullied by the management team, another person told us living in the home was awful and a third person was happy with the support.

● Evidence-based guidance was not current and did not enhance people's care. People experienced poor outcomes from an outdated approach to care that did not seek to meet people's preferences or equality characteristics. Staff had not received training relevant to their role. Following the inspection, the registered manager arranged additional training sessions so people's needs could be more positively supported.

Working in partnership with others

● The provider had worked with healthcare professionals such as GP's. However, referrals to specialist professionals such as dieticians had not always been made in a timely manner, placing people at risk of

harm. Multi-agency reviews of people's support needs did not occur frequently, leading to people's health and well-being deteriorating as a result.

● The provider was a member of a local training and management support organisation. They had not, until this inspection, sought training, guidance or support to address the concerns identified in this report.