Health & Care Services (NW) Limited

Orchid Lawns

Inspection report

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30 November 2020

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Orchid Lawns is a residential care home providing accommodation for older people, who may be living with dementia, a physical disability or mental health needs, who require nursing or personal care. At the time of our inspection, Orchid Lawns was supporting 16 people, many with complex needs and advanced dementia.

People's experience of using this service and what we found
Effective arrangements were not in place to manage and reduce risks for people using the service and lessons were not always learned when things went wrong. Staff were not effectively deployed to ensure people's needs were met and did not put their safeguarding knowledge into practice to protect people. Improvements were being made in the management of medicines. Infection control processes were in place.

Staff were not provided with the training, skills and information they needed to care for people effectively. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. People received food to meet their individual dietary needs, however the mealtime experience was not relaxed. Referrals were made for additional support to other professionals when needed.

People were not always engaged in meaningful activities to ensure their wellbeing. Although care plans were in place, they did not always contain information to guide staff and staff did not have time to read them.

Management, leadership and governance arrangements did not provide assurance the service was well led, that people were safe or their specific and complex needs were being met. There had been an increase in safeguarding concerns over the last six months. We were not assured the provider's plan for improvement focused on the right areas to ensure a positive impact for people.

We received positive feedback from relatives that staff were kind and caring, however the care was not always attentive, and staff did not have time to spend with people.

We raised a safeguarding referral with the local authority regarding some of our concerns after the inspection.

Rating at last inspection
The last rating for this service was Good (29 May 2019)

Why we inspected

The inspection was prompted in part by notification of a specific incident following which a person using the service died. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The inspection was also prompted due to concerns about people receiving poor care and support, ineffective safeguarding processes and concerns related to a lack of managerial oversight and leadership. A decision was made for us to inspect and examine those risks. We inspected and found further concerns which impacted on other areas of the quality and safety of care. We widened the scope of the inspection into a comprehensive inspection which included all the key questions.

We have found evidence the provider needs to make improvements. Please see the safe, effective, responsive, caring and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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 coronavirus and other infection outbreaks effectively.

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

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk management, staffing, governance, leadership and oversight and statutory notifications.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. 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.	**Inadequate**
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 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**

Orchid Lawns

Detailed findings

Background to this inspection

The inspection
The inspection activity took place between 15 October 2020 and 30 November 2020. We visited the service on 18 and 19 November 2020.

Inspection team
This inspection was undertaken by three inspectors.

Service and service type
Orchid Lawns 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 manager registered with the Care Quality Commission. 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. The registered manager was not currently at work and an interim manager was in place.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We requested information from the provider prior to the inspection and this information was used as part of the inspection plan.

During the inspection
We spoke with fourteen members of staff including care workers, registered nurses, agency staff members, the chef, the interim manager, the associate director of quality & governance, the operations director and the managing director. We spoke with eight relatives. We reviewed a range of records including care plans, risk assessments, daily notes, incident and accident records and rotas. We also reviewed records relating to the management of the service and minutes of meetings held with external professionals.

After the inspection
We continued to seek clarification from the provider to validate evidence found and sought feedback from two professionals.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

- Risks to people's safety and wellbeing were not effectively monitored and managed. Two people were in the conservatory unsupervised. One person was at high risk of falls and their care plan stated staff should always know their whereabouts in the service. Two staff members supervising the communal areas were unsure if it was that person in the conservatory. This person usually wore glasses; however, they were not which put them at further risk of falling. A staff member told us they had broken but at the end of our visit, we saw the person was wearing glasses.
- Where people could become distressed or upset, there was limited information to guide staff on how to effectively support them. For example, one risk assessment stated the staff member should, 'Try and provide enough mental and physical stimulation.' It did not give any clear information on how the staff member should do this.
- Unsafe moving and handling practice at the service placed people at risk of harm and there were concerns regarding unexplained bruising. One staff member told us, "I've seen people put into slings they have not been assessed for and there was no risk assessment or care plan in place to evidence hoisting was required." One relative said, "[Person] has bruises and nobody seems to know how it has happened." Minutes from a team meeting in October 2020 identified staff members, including nurses, had been using inappropriate techniques which had not been reported to or been identified by the management team.
- Information about known risks to people was not communicated to staff. An agency staff member was supporting a person at a very high risk of falls. When walking the person was stooped over and looking down at the floor, and the agency staff member was supporting them by holding their hand. Their care plan instructed staff for the person to link arms with them. This would encourage the person to stand upright and help prevent falls. The agency staff member told us they had not read the care plan so would not have been aware of this information which placed the person at further risk of falling.
- Although falls were logged, the specific details of the falls such as the location were not logged. This would enable the management team to look for themes and trends and put additional measures in place to reduce the risk of the falls happening again.
- Safeguarding competency checks were being completed with staff to assess their understanding in safeguarding people from abuse. However, staff had not recognised the importance of raising concerns regarding poor moving and handling practice in a timely manner to ensure people were protected. Poor moving and handling practice had then continued which placed people at risk of harm.

Learning lessons when things go wrong

- Poor moving and handling practices had been raised by a GP surgery in July 2020, however this concern was raised again in October 2020 which showed lessons had not been learned and people were still being

placed at risk of harm.
● When incidents had occurred and people had become upset, staff had not recorded relevant information such as any contributing factors or emotions the person was displaying. This could help to identify any potential triggers, themes or trends and help identify any lessons to be learned to prevent incidents happening again.

People were not protected against the 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
● On the day of inspection, staff did not have time to spend with people. One person requested help and was told to take a seat as the staff member couldn't leave the lounge. They received help twenty minutes after their initial request. One staff member told us, "I haven't updated the charts as not had time as been doing everything else. I should finish at 7pm, when I know it takes until 7.30 pm to do it properly. I end up working late, writing up notes and the supervisor keeps pushing me." We observed one person was anxious and wandering around the service. There were no staff members in the area and the inspector had to ask a senior manager to intervene and support the person.
● We received feedback that there were not enough staff. One relative said, "When I was able to visit, there were not enough staff. They used to have five staff in the lounge one day and only one the next." One staff member said, "I couldn't get to support those cared for in bed until the afternoon as there are not enough staff and the pads were leaking because they were so full." Another staff member said, "It can be difficult because sometimes only two staff at night. We also have two people who require one to one support and sometimes agency staff don't turn up. The permanent staff member then has to support two people with one to one support which just leaves one staff member to support everyone else."
● Rotas between the period of 26 October 2020 to 22 November 2020 showed 26 agency staff members worked at Orchid Lawns and most of these only worked one shift. The lack of consistent staffing meant staff did not know people well and this impacted on the organisation of the shift. One staff member said, "Staffing levels need a lot of improvement. We work with a lot of agency staff, and they do not know how to fill in forms and this impacts on the workload as you must do their work too." Another staff member said, "Agency nurses do not know the people we care for which makes the job really hard for the long-term staff as they have no one to go to who know the people for advice."

Staff were not effectively deployed to meet people's needs. This was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

● Where agency staff were being used, profiles were in place giving information about their previous experience of working in care. Checks had been carried out to ensure their suitability to work with vulnerable people.

Using medicines safely
● Staff and the management of the service had not been effectively working with the GP surgeries. We received concerns about poor medicines management and issues with ordering medicines.
● There was a lack of managerial oversight of medicines management. One person had not received a prescribed medicine for five days. This was a medicine used to control blood pressure and staff had not documented the missed medication. The error was not noticed for five days.
● Following this, the management of the service had introduced end of shift medication checks. However, this was ineffective because these checks did not identify where one person had not received their blood thinning medicine for nine days, placing them at risk of a blood clot.

● The service had recently had a visit from the medicines optimisation team and were working with them on areas for improvement.

Preventing and controlling infection

● The provider was making sure infection outbreaks could be effectively prevented or managed through the hygiene practices of the premises.

● There were effective systems in place to help prevent and control the spread of COVID 19. These included testing of staff and people using the service, the safe use of PPE and following shielding and social distancing rules.

● Measures were in place to admit people safely to the service and to prevent visitors from catching and spreading infections.

● The provider's infection prevention and control policy was not up to date. We were assured this this would be addressed and did not impact on the infection prevention processes within the service.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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

- Despite the providers stating on their website that they provided a specialist dementia nursing service, the care and support delivered did not always reflect current evidence-based guidance or best practice.
- The provider stated on their website that all staff received accredited dementia training to ensure they had the skills to provide effective support. However, this was not the case and only nine staff out of 25 had received accredited training in dementia care. When asked about the dementia training, one staff member said, "I can't fully remember what this involved but we deal with some very challenging people at Orchid Lawns."
- Staff either did not know how or have the relevant information they needed to support people with dementia effectively and this was shown in their practice and approach. They did not interact with people who were expressing their anxieties with any meaningful and purposeful activity which would help distract and calm them and promote their wellbeing.
- One person's care plan stated for staff to use the skills they learned in their training. A member of the senior management team confirmed the staff member supporting this person had not received the accredited training in dementia. The agency staff member consistently followed the person in their care around, placing themselves in the person's personal space and constantly asking them what they wanted to do which could provoke additional stress and anxiety.
- Temporary agency staff members were supporting people at the highest risk and with the most complex needs on a one to one basis without having the skills and understanding to meet their needs. For the duration of our visit, the agency staff member was trying to encourage the person to play the piano although the person could not play and wasn't interested. This approach was not in line with the person's care plan.

Staff support: induction, training, skills and experience

- Staff received training in subjects such as fire safety and pressure care, however they were not always able to demonstrate the training had provided them with the knowledge they required. One staff member was unable to give any detail regarding how to manage pressure care and said, "I just do what I am told." Another staff member was not able to confirm whether specific training on pressure care equipment had been done.

Staff did not receive appropriate training to meet people's needs. This was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

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

● People's individual needs were not always met by the design and decoration of the service. There were some sensory items on the walls of the corridors and people had memory boxes outside their bedrooms. However, we did not see any other comfort or interactive items being used to stimulate thoughts and memories which are important when caring for people with dementia. The provider told us this was due to COVID-19, however the use of such items could have been risk assessed to reduce the spread of infection.
● Communal areas were not used effectively. Despite there being more than one lounge for people to use, everyone was gathered in one area of the service which made it noisy, particularly with the addition of loud repetitive music and the piano. One staff member tried to engage a person in a book, however they had to raise their voice so the person could hear them.

Supporting people to eat and drink enough to maintain a balanced diet
● Lunchtime was chaotic and busy. Staff were rushing past tables where people were eating, and the environment was not calm and relaxed which would encourage people to eat and have an enjoyable mealtime experience. Staff did not appear organised and lacked any direction by a senior staff member.
● One person was supposed to have six small meals a day and their care plan stated staff should sit with them to encourage them to eat, however biscuits were placed in front of the person and a staff member was not allocated to sit with them. One staff member said, "Usually at the start of the shift we get an allocation, but this wasn't done yesterday and has been an issue since I have been here. Usually one person in the lounge who offers drinks. We sort out between ourselves who is going to support who with meals."
● Staff including the chef were aware of people's dietary needs and recommendations from Speech and Language Therapy (SALT) and people were provided with food according to these recommendations on the day of inspection. One staff member said, "People have food charts in their rooms and a sheet that tells us if someone has thickened fluids or a special diet." One relative said, "[Person] is on a soft diet and has swallowing difficulties and staff got (SALT) out. This is monitored and [person] is given enough to eat and drink in the right texture."

Following our feedback to the interim manager, we were told a quality check of the dining experience would take place to ensure the mealtime was relaxed and enjoyable and any improvements would be made immediately.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The service worked with health care professionals to meet people's care needs although recommendations were not always documented in people's care plans. One person had been supported by physiotherapy and had been discharged with some exercises to complete. There was no information in the care plan to provide guidance for staff on how to complete the exercises and the person was not wearing the hand protectors as advised.
● Where people required additional support, referrals were made to other agencies, for example dietician services.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the

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

● Staff had a basic understanding of the MCA and had received training in this area. One staff member said, "It's all about decisions and asking people for consent." Another staff member said, "I understand you cannot assume a person lacks capacity unless it is proven."

● Although capacity assessments and best interest decisions were in place, these were not always specific to one decision. For example, one capacity assessment covered living in a secure environment, medication administration and the sharing of data. This is not in line with MCA guidance as different decisions and the issues are not related to each other. A person who lacks capacity would not be able to weigh up this level of information in one conversation.

● Best interest decisions had been made in relation to people having a COVID -19 test. However, there was no plan in place to instruct staff on the best and least restrictive way to carry this out or what they should do if the person said 'no' and resisted having the test done.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Although some relatives said staff members were kind and caring and we received comments such as, "Staff will always acknowledge [person] even if it's just getting down to her level to say hello or touching their hand gently," our findings did not suggest a consistently caring service.
- Staff were not always attentive to people's needs and the environment was not calm and relaxed. Twice on the day of inspection, the same song was playing loudly and continuously on repeat in the lounge. This was not noticed by the staff team. One person became very vocal and was shouting. A staff member was supporting them to eat and the music drowned out any conversation. It had not been considered by staff this could be due to the music.
- Staff were rushed and did not have time to spend with people. One person was trying to put a food covering onto another person in the lounge. The person was becoming upset and trying to push the other person away. Although staff were in the area, they were occupied and did not notice or intervene.

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

- We received mixed feedback regarding relative's involvement in people's care. Some relatives had been involved in an annual review and others had not seen the care plan and did not know what was in it. There was no evidence within care plans that people and their relatives had been involved.

Respecting and promoting people's privacy, dignity and independence

- At lunchtime, one person was being supported with their meal. The staff member was knelt on the floor next to them, was not sat at their eye level to improve communication and was not engaging with the person. It would have been more encouraging, relaxing and respectful if the person had sat on a chair next to them.

Requires Improvement

Is the service responsive?

Our findings

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

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

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

- People did not receive care that was planned, personalised or responsive to their needs. There was a lack of clear guidance and key information for staff to enable them to consistently deliver the right support to people.
- Although there were care plans in place, they were large, repetitive and some contained information not relevant to people's current needs. Staff told us they did not have time to read the information in them. One staff member said, "No time to read care plans because we are always busy." Another staff member said, "I wish I could have more time to read care plans, but we are very focussed on our job and there are a lot of unpredictable and demanding situations."
- Staff referred to people's one-page profiles which gave them an overview of individual's key needs. However, we found some of these missed relevant and important information needed to deliver personalised and responsive care. For example, re-positioning to prevent the breakdown of their skin and how to engage and interact with each individual to promote their wellbeing.
- Daily care records did not show how the service responded to people's differing needs in terms of interests and social activity and contained impersonal information such as, 'Safety maintained, medicated and remains stable.' Despite this being brought to the providers attention by health and social care professionals, no action had been taken to address it.
- Despite the providers declaring on their website the service promoted and supported 'meaningful occupation, independence and maintenance of identity,' people spent prolonged periods of time disengaged with limited engagement or meaningful interaction. Relatives told us there was limited stimulation or activity. One relative said, "Not enough stimulation for [person]. This has caused a deterioration in their mental health and physical health." Another relative said, "When I do go in, I don't see any activities going on and there is no newsletter or event log etc."
- On the day of the inspection, the activities co-ordinator was unwell, and staff were allocated activities, but staff did not undertake any meaningful activity provision or engagement with people.

People did not receive individualised care which met their needs. This was a 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 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.

● We received feedback that where some staff did not have English as their first language, this impacted on the communication with other staff members, relatives and with the people they were supporting. One staff member said, "There is lack of communication, as some staff do not speak clear English and people do not understand what they are saying." One relative said, "Can't understand the staff when they answer the phone and they can't understand me either." This could lead to people becoming frustrated and their individual needs not being met.

Improving care quality in response to complaints or concerns

● We received feedback that most relatives knew how to make a complaint. One relative said, "We were given some information and there is information on the website about complaints. I have never had to make a complaint. If ever had a query, speak to staff and it has been sorted out and dealt with."

End of life care and support

● Some staff had received training in end of life care.

Inadequate

Is the service well-led?

Our findings

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

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

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

- Although there was a registered manager in post, there had been periods of time when they had not physically been in the service. There had not been consistent management at this service since the end of March. The lack of oversight and monitoring led to a deterioration in the service placing people at risk of poor care. One staff member said, "I have come on shift a few times and body maps have not been followed up. I document three or four marks for a person on a body map and then I am off for two days and there has not been continuous checking and monitoring." Safeguarding concerns had increased significantly since our last inspection. Since October 2019, the Local Authority reported there were 26 safeguarding concerns received of which nine had gone to investigation.
- There was a lack of leadership, direction or effective role models to lead and support staff. The provider had allocated a senior management team to oversee and improve the service. Despite the presence of four senior managers on the day of inspection, they were not visible, and it was unclear what leadership, oversight and support they were providing to ensure positive outcomes for people.
- We received feedback from the staff team that the management support was inconsistent. One staff member said, "There is no support on weekends, just a manager on call. No one I can talk to as nurses are agency and do not know the people or processes. Weekends are a wash out. I dread working at the weekend." Another staff member said, "When the manager leaves at 5pm, there is only one nurse on shift who takes on the responsibility of the manager. It can be very stressful making decisions without any support."
- On the day of inspection, the shift was disorganised and at times, chaotic. Staff allocation sheets did not cover support for individuals at mealtimes or observation of people at high risk of falls. Staff had to request breaks and agency staff were supporting people with the highest needs with limited knowledge or training of how to effectively and safely support them. One staff member said, "Work is unorganised here. The senior does not know how to organise the shift. The staff morale is very low as we have more agency than permanent staff. Feels like they [provider] have got people off the street." Another staff member said, "There is no communication between staff. Staff do their own thing and don't care by rushing their work."
- The contract compliance visit undertaken by the local authority in May 2019 found there was limited social stimulation for people and a lack of staff supervision. The concerns with activity provision had also been raised at our previous inspection visit. These areas continued to be a concern demonstrating a lack of lessons learned and improvements made and sustained.
- In response to local authority concerns, senior managers developed an action plan. This was difficult to

navigate to check progress of actions in the key areas of concern. It was recorded on the action plan individuals had been reviewed to ensure fluid monitoring was in place in accordance with their risk of dehydration. This was incorrect because one person was not having their fluid intake monitored despite not being able to independently drink and therefore at risk of dehydration.
● Where concerns had been raised regarding the language barrier of some staff where English was not their first language, this was not on the action plan to evidence how this was being addressed and how these staff were being supported.

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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We received feedback that relatives were not kept up to date with their family members health and wellbeing. One relative said, "I don't get told anything from the service. My biggest query is the lack of communication. I only get messages when something happens." Another relative said, "The lack of oversight is driving me nuts. I would involve the family more. There needs to be an interface which is missing."
● There were elements of a closed culture within the staff team and leadership of the service. We received feedback that issues were not always dealt with and two relatives we spoke with were worried about raising concerns in case it impacted further on the care. One staff member said, "All concerns or complaints are brushed off and not taken seriously, or it is thrown in your face that you need to work harder." There was not a culture which proactively identified issues and learned from them. We received feedback that the registered manager had demonstrated an 'unwilling nature' to support with enquiries from social workers and other healthcare professionals where incidents had occurred in the service.
● Staff were not receiving regular supervision and did not always feel supported. One staff member said, "I can't remember when my last supervision was. I think it is twice a year." Another staff member said, "Last supervision was January 2020 and I was just told what areas I was doing badly in and was not allowed to voice my opinion. Not really a two-way process. Hoping it will change with new management."

Effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations. This was a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

● There was a lack of oversight to ensure notifications were made to the commission. Although 26 safeguarding concerns had been received by the local authority, the commission had only been notified of half of these. There was a delay in notifications regarding DoLs authorisations and seven of these were completed retrospectively.

Statutory notifications had not been submitted as required to the commission without delay. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

● We received positive feedback about the interim manager, however they were only in post for two weeks. Comments included, "The interim manager is very supportive and approachable. They listen and sorts things out." And, "We have been getting a lot of help from the interim manager. Listens and gives me time to explain myself and they will discuss with you things you do not understand and explain what will be done about it."

Working in partnership with others
● The service worked with others, for example, district nurses and the local authority safeguarding team.

However, professional recommendations and advice were not always followed as documented within this report.

● A meeting had been held with the local GP surgery which had been positive in to improving working relationships.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not submitted statutory notifications as required to the Commission without delay. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care to meet their individual needs and preferences. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected against the risks associated with the environment or their individual needs. Regulation 12 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Leadership and governance systems were not effective to monitor the quality and to assess and mitigate risks to people using the service

	Regulation 17 (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not effectively deployed to meet peoples needs. Regulation 18 (1) Staff did not have the skills and training needed to support people competently. Regulation 18 (2)(a)