The Lombrand Ltd

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Inspection report

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07 January 2022
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19 January 2022

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

Summary of findings

Overall summary

About the service
The Lombrand is a residential care home providing accommodation and personal care. The home accommodates up to 21 people living with mental health conditions. At the time of our inspection 16 people were living at the home.

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

People did not receive a safe, person-centred and well led service.

The service was not safe. Appropriate standards of hygiene had not been maintained in all areas. Effective infection prevention and control (IPC) measures were not always followed by staff and management. Risks in relation to infection control, people and the environment had not been fully considered and managed and there was limited action to prevent reoccurrence when things went wrong. Medicines were not always managed safely. This placed people at risk of harm.

The service was not always caring. People told us they were not always treated with kindness, dignity and respect. Independence was not always considered and promoted. People were not always involved in making decisions about their care and support.

The service was not always responsive to people's needs. Care was not person centred or delivered in line with people's preferences and wishes. This put people at risk of harm or poor care. Relatives told us communication was poor and they were not consulted or involved in their relatives' care when people required support to make decisions. Government guidance in relation to visiting had not been followed. People told us they experienced isolation.

The service was not well-led. We found widespread and systemic failings throughout the service. Audits were not effective in driving forward improvements within the home. Policies and procedures were not consistently followed to maintain safety. Good practice guidance was not always considered and implemented. Records were not always accurate, up to date and reflective of people's needs.

Staff were not always provided with training and support to complete their role. We identified gaps in training and staff knowledge. Supervision systems were in place, were not robust and not all staff received regular supervision in line with the provider's policy.

The principles of the Mental Capacity Act were not always followed. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; policies and systems in the service did not support this practice.

Staff did not feel supported in their roles and described a culture of blame and bullying. Staffing levels

within the service were not sufficient to enable staff to engage with people, support people with activities or to access their local community.

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

Rating at last inspection
The last rating for this service was good (published 15 May 2020).

Why we inspected
We carried out a targeted inspection on 07 January 2022 to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about COVID-19. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with the provider following COVID-19 guidance, so we widened the scope of the inspection to become a comprehensive inspection which included all the key questions of safe, effective, caring responsive and well-led.

We looked at IPC measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to 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 multiple breaches in relation to person centred care, safe care and treatment, safeguarding, consent, dignity and respect, staffing and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will 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.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always 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 always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Lombrand Limited

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.

Inspection team
The inspection was carried out by two inspectors on days one and two and three inspectors on day three of the inspection.

Service and service type
The Lombrand 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 CQC. 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.

Notice of inspection
All three days of the inspection were unannounced. Inspection activity started on 07 January 2022 and finished on 19 January 2022.

What we did before the inspection
On receiving concerns about the service, we asked the provider to provide a response to the issues raised. We reviewed information they provided. We sought feedback from the local authority and reviewed all the information we had received about the service since the last inspection. We used all this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. 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.

During the inspection
We spoke to seven people who used the service and one visiting professional about their experience of the care provided. We sought views from three family members. We spoke to ten staff members, the registered manager, and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a selection of records. This included a variety of people's care plans, medication records and staff files in relation to recruitment and training. A variety of records were reviewed in relation to the management of the service, including policies and procedures and audits that had taken place.

We conducted a walk around of the service and spent time observing staff interactions with people and practices.

We sought support from the local infection protection control and the fire service for specialist advice.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures and care plans for people. We liaised with Commissioners, local authority safeguarding teams, fire and rescue and the infection control team to share our findings so they could act accordingly.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.
http://crmlive/epublicsector_oui_enu/images/oui_icons/cqc-expand-icon.png

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

- People were not always safeguarded from the risk of abuse. People living at the home told us the culture did not always make them feel safe. From documentation reviewed we saw multiple examples of people being restricted of their liberty without consent.
- Staff told us they were not supported to raise safeguarding concerns and felt actively discouraged and fearful to whistle blow. Additionally, two staff told us they were not fully confident in how to raise concerns.
- Not all staff were up to date with safeguarding training. Two staff confirmed they had not received this training.
- The provide had failed to follow local safeguarding arrangements to report all incidents to the local authority safeguarding team. This breached the organisations own policy on reporting and responding to safeguarding concerns.

The provider had failed to ensure that people were safeguarded from preventable harm. This was a breach of regulation 13 (safeguarding residents from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- We could not be assured that lessons were learned from incidents. Following incidents within the service, reviews and investigations were either not completed or were not sufficiently thorough. For example, one person who had experienced a choking incident, but this had not been reflected in their risk assessments or care plan. No referral had been made to any professional for advice and guidance to ensure this risk was addressed to prevent any reoccurrence.
- Staff did not always recognise or record near misses. There was missed opportunity for learning. For example, medication audits had identified that some medicines had been incorrectly supplied by the pharmacy, resulting in an overdose of prescribed medicines for one person. These findings had not been clearly recorded and reflected upon.
- We found incident analysis to be poor and did not consider the dignity or needs of the people involved.

Systems were either not in place or robust enough to demonstrate learning from incidents had taken place and had been established and operated effectively to prevent abuse. This placed people at risk of harm. The provider had failed to ensure that people were safeguarded from preventable harm. This was a breach of regulation 13 (safeguarding residents from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider has been receptive to our concerns and started making changes during the inspection to prevent people from being exposed to the risk of harm.

Assessing risk, safety monitoring and management

●The provider had failed to consistently assess, monitor and review risk. Individual risk was not always considered and addressed. For example, when people had identified medical conditions such as diabetes, the risk associated with these medical conditions had not always been considered.

● Environmental risk was not always identified and acted upon. Environmental checks had not always been completed as required. The provider was unable to provide evidence and reassurances of up to date gas safety certificates and legionella safety check records.

● Areas of the environment needed addressing in order to be made safe. For example, one fire exit had been blocked which had not been identified by the provider as a key risk. The provider ensured this was made safe following the inspection.

● The provider had not completed all adequate fire safety checks, putting the residents at risk in the event of a fire. The service did not have evacuation plans in place for people at the service.

The provider had failed to assess and monitor risk to keep people safe from 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.

Following the inspection, we requested immediate reassurances from the provider.

Preventing and controlling infection

● Guidance in relation to IPC was not always considered and implemented. Staff did not always wear Personal Protective Equipment (PPE) appropriately. For example, we observed staff not wearing masks in the building. We highlighted this to the provider. who instructed all staff to wear appropriate PPE. However, following this instruction this was still not followed consistently by all staff.

● The service was not always clean. Carpets in two bedrooms and flooring was stained, bedding in use was not always clean. We observed surface level dust and cobwebs around the building.

● Practice did not always prevent the spread of infection. For example, visitors were not consistently screened in accordance with COVID-19 guidance.

● Staff had not received training in, or understand their responsibilities in relation to reducing infection.

● We were not assured that the provider was accessing testing for staff in line with the guidance throughout the pandemic. This has left people at a greater risk of COVID-19.

● The manager's records regarding vaccination status were not robust and did not offer assurances.

The provider had failed to ensure effective infection and prevention control measures were in place. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

The providers approach and arrangements for visiting within the service did not align to current government guidance for visiting. (Department of Health and Social Care Guidance on Care Home Visiting). Relatives we spoke with told us they had not been kept up to date with visiting arrangements within the service.

Care homes (Vaccinations as Condition of Deployment)

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

emergency. We checked to make sure the service was meeting this requirement. At the start of inspection, we found that processes for ensuring staff were suitably vaccinated were not robust and thorough. We highlighted this to the registered manager who agreed to take action.

Using medicines safely

● Medicines were not always managed safely.

● People did not always get their medicines as prescribed. People had been given a different amount of medicine which differed from prescriber's instructions and there were no records available to show any changes to people's prescriptions made by the relevant healthcare professional such as the pharmacist or GP.

● Not all staff had completed medicines training.

● The management of 'as and when required' medicines used to support people in times of need or distress, were not suitably recorded and care plans did not give staff clear guidance on when these were to be used. For example, an 'as and when required' protocol for a service user's inhaler detailed 'a dosage of two doses as needed up to four times daily'. There was no guidance in place, to explain what circumstances this was required to be administered.

● Medicines were not always stored in line with current guidance. For example, some medicines which required to be stored at a specific temperature, were not being stored safely in line with prescriber's instructions. This had not been picked up and addressed.

● Senior staff members carried out medicines related audits; however, where issues were identified they were not documented and investigated appropriately.

Systems were either not in place or robust enough to demonstrate medicines were safely managed. This placed people at risk of harm. The provider had failed to ensure the proper and safe management of medicines. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The provider did not always provide enough staff with the right mix of skills, competence, or experience to support people to stay safe. There were two staff members on each shift to support 16 people. Staff were responsible for providing all care tasks as well as completing the cleaning, laundry, provision of activities and preparation of meals.

● People told us there wasn't always enough staff to support them. People had to wait to have their needs met. One person waited 20 minutes for the door to be opened so they could leave the building. One person told us they were unable to do what they really wanted to, as they were reliant on staff availability and 'there was never enough staff ' to support them. Another person said, "They definitely need more staff. They are always under pressure. We have to wait even just to go out for them to unlock the door." ● Staff told us, "We are run off our feet and have no time for the residents" "We have so much to do, between cleaning, cooking and medication - we don't get to spend any time with residents" and one staff told us, "I just can't meet their needs, I am obstructed."

Systems were either not in place or robust enough to ensure sufficient numbers of suitably skilled and experienced staff were in place to meet the needs of the people using the service. The provider had failed to have enough staff to meet people's needs. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not considered completing regular in-house employment checks to ensure staff remained of suitable character. We highlighted this to the provider so they could consider making

improvements and strengthening their recruitment policy.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

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

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

● The registered manager sometimes lacked knowledge of the MCA and there was a failure to understand when this needed to be applied. As a result of this, people sometimes had inappropriate restrictions placed on their everyday choices and control. For example, we observed people not being able to eat and drink at times they chose to or leave the home when they wished to do so.
● People had been deprived of their liberty without the legal authority to do so.
● Consent was not always achieved. Blanket decisions had been made for people without consideration for their wellbeing. regardless of their capacity.

Systems were not in place to ensure consent was always achieved, in accordance with the principles of the Mental Capacity Act 2005. This was a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills, and experience
● Not all staff had suitable training to complete key tasks for their role. For example, specific training could not be evidenced for staff members responsible for administering medication. In addition, we saw there had been an incident when two staff on duty had not been provided with first aid training. This had led to a delay in treatment for one person.
● There were gaps in staff training. The registered manager could not provide us with assurance that staff had received all the required training as specified as necessary for the role as indicated on the training

matrix. One staff member told us they had not completed any training since they started working for the provider.
● Staff confirmed they had not had their competency assessed to ensure they had the correct skills to administer medicines or put on and take off their personal protective equipment. We spoke with the registered manager who confirmed these checks had not taken place.
● Staff did not receive regular supervision or appraisals in line with the company policy. This meant staff were not given the opportunity to reflect on their practice, raise concerns or celebrate achievements of people. The provider had failed to ensure staff received supervision in line with the provider's policy of every two months.

Systems were either not in place or robust enough to ensure staff were suitably skilled to meet the needs of the people using the service. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People's diet and nutritional needs were not always met. Some people said they did not always get enough to eat or drink. People told us they did not always get the opportunity to be involved in the planning of meals and were not always offered choices.
● Meal and drink times were set by the provider and lacked flexibility to take into consideration people's individual preferences. We observed people being denied a drink at a time of their choice.
● The provider did not always ensure people's dietary needs were considered and met. For example, no consideration had been taken to ensure people who required low sugar diets were always catered for.

Systems were either not in place or robust enough to ensure service users nutritional and hydration needs, having regard to the service user's well-being. This was a breach of regulation 9 (Person–centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us the food provided was of a good quality.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We could not be assured people's needs and choices were always assessed and considered so care could be delivered in line with standards, guidance and the law. Good practice guidance was not referred to in people's care plans and we were not fully assured it was consistently followed.
● Information in people's care plans was not up to date for staff and to provide effective support. Care plan audits were inconsistent; we found some care plans had not been reviewed for some months. Where actions had been identified to update people's information, this had not always been completed.

Systems were either not in place or robust enough to ensure people's needs had been assessed. This was a breach of regulation 9 (Person–centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● Areas of the environment required addressing. For example, the smoking area for residents was cluttered with litter, cigarette ends and covered with moss. Areas of the service, including bedrooms, needed decorating and maintenance work to ensure a consistent standard throughout. The provider took steps to improve these areas for people following our inspection.
● The provider had made some decisions about changing or altering the environment without involving people.

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

- The provider monitored people's health but did not consistently act on issues identified.
- The provider did not ensure that people always had choice and control over their health needs, where this was possible.
- Systems and processes for referring people to external services were inconsistent. We found arrangements were in place to make a doctor's appointment for one person who could access this independently. However, for another person who we observed to be unwell, staff had to be prompted to make an appointment for this person. Following the inspection, the registered provider provided assurances a GP appointment had been accessed for the person.

We recommend the provider review systems and processes to ensure access to healthcare services is consistently addressed.

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 this key question was rated as 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.

Respecting and promoting people's privacy, dignity, and independence; Supporting people to express their views and be involved in making decisions about their care

- People's independence was not always promoted; multiple restrictions had been placed upon people that compromised people's independence. For example, we identified restrictions such as not being able to access the community, not being able to eat and drink when people chose, limited access to money and limited access to personal items. People confirmed such decisions had been made without appropriate conversations with them.
- People told us they were not involved in planning their care. Records viewed within the service confirmed this was the case. For example, we observed restrictions had been placed upon one person but there was no evidence these restrictions had been discussed and agreed with the person. We spoke with the person about these restrictions, they confirmed they had never been included in any discussions.
- People without relatives did not have an advocate or been given an opportunity to access one. Advocates are independent people who can assist people to express their views and wishes.
- During the inspection, we observed staff talking on behalf of people rather than supporting people to express their own opinions.

Systems were either not in place or robust enough to ensure people were being supported to promote their dignity and independence. This is a breach of regulation 10 (Dignity and respect) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- We received mixed feedback about the caring nature of staff. People told us they did not always feel well treated or respected. Whilst some staff were described as caring, others were described as 'not caring', 'bossy' and 'sarcastic.'
- We observed one person approach two staff members for support. Neither offered them eye contact or stopped to listen to them, staff continued to talk between themselves without acknowledging the person at all.
- Staff told us the provider did not recognise, value or encourage a kind and caring approach and said care was focused on a task orientated approach.
- We highlighted these concerns to the registered person who provided us with some assurance that action would be taken to improve the culture.
- We observed staff knocking before entering people's rooms and asking for permission before entering. People told us this consistently happened, and they felt their privacy was protected.

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 good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- The provider did not meet people's individual needs in relation to maintaining interests and hobbies, maintaining relationships or contact with the community. People told us they often relied on staff for social activities and said that staff did not have enough time to engage with them. They told us, "Some people are not allowed out at all, it is really bad," and "I can only go out with staff, but there is never any staff to take me."
- Two relatives we spoke with told us their loved ones were not supported and encouraged to maintain links with them and the only contact made was when they initiated calls and requested information.
- There was no structured programme of activities in place. We reviewed daily activity logs and saw activities recorded detailed 'watched television', 'watched the soaps', 'relaxed in the lounge' or 'went to the shop.' People told us they had previously enjoyed different activities but there was nothing for them to do as staff were too busy. Staff told us that there were board games and books available, but they were not a reflection of people's interests.
- People were not always supported to maintain relationships with family and friends to avoid social isolation.This had been in part due to the risk of COVID-19, but alternatives had not been considered to support people to access their local community safely while mitigating risk.

Systems were either not in place or robust enough to plan personalised care according to people's individual needs and wishes. This is a breach of regulation 9 (Person centred care) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care was not always personalised to meet the needs and preferences of people who lived at the home. The provider had failed to ensure care and support was designed to meet people's needs. Each person had a plan of care in place, but these were not always personalised. Staff told us personal information about people which was not reflected in care plans.
- People were not involved in developing their care plan; their individual needs and circumstances were not taken into account. For example, one person told us that access to exercise was important to their mental health However. the provider had not supported this and had restricted the person's activity to only leaving the service for one hour a day for a local walk. They told us that this had had a negative impact on their wellbeing.
- Care records did not always include all key information required to safely support people. For example, when people had specific medical conditions, information was not always documented about how the

medical condition presented and how to safely support the person. Staff told us information in care plans for people with diabetes did not provide them with the information they required to support people.
● The care and treatment provided by the service was task-centred rather than in response to people's individual needs and preferences. People's care and support plans would refer to 'when staff were available'; promoting a task centred and institutionalised approach to care. One person told us, "I don't feel like it's my home, I'm just a resident and pay the bills."

Systems were either not in place or robust enough to ensure people's needs had been assessed. 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 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● The provider had not taken any steps to comply with the Accessible Information Standard to identify, record, share and meet the information and communication needs of people using the service
● Signage around the building was inconsistent. For example, an easy read poster had been displayed about topics such as COVID-19 but the service user guide, menus and nutrition information had not been adapted.
● The provider had failed to identify a person's communication needs and had declined to offer information in an alternative format when asked to do so. Staff told us the person had requested their Christmas gift labels be replaced with a photograph of the person giving the gift, but this had not been provided.

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

Improving care quality in response to complaints or concerns
● Systems and processes for managing complaints were not always robust. Staff and people told us they were not assured any concerns or complaints they raised would be dealt with in line with the providers policy.
● A complaints policy was in place. We asked the provider for the complaints log and they confirmed they had not received any complaints since the last inspection. However, following the inspection, we were provided with copies of complaints that had been sent to the provider. We could not be fully assured therefore the process was effective.

We recommend the provider seek advice and guidance from a reputable source, about the management of and learning from complaints.

End of life care and support
● The provider was not supporting any people with end of life care at the time of our inspection.
● People at the home had a personalised end of life care plan detailing their preferences to equip staff to support them at 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.

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

- The culture within the service was not consistently person centred and did not achieve good outcomes for people. Systems and processes did not promote person centred care. For example, staffing calculations and management of unplanned absence infringed on people's choices and rights.
- Staff described a culture of bullying within the service and told us they did not feel empowered to provide good quality care. Staff told us they felt uncomfortable raising concerns or challenging poor practice.
- People told us they were not confident in raising concerns and believed they would not be acted upon. Members of staff we spoke with confirmed that residents were fearful of expressing their views.
- Action had not always been taken to improve people's lives. Processes for ensuring the upkeep of the building were not robust to ensure people's wellbeing was always considered.
- The provider had failed to act on a commissioner's direction to apply for a DOLS; due to this a person was being deprived of their liberty without the appropriate safeguards or legal authorisation in place.
- People, staff, and relatives were not being asked in a meaningful way about their views of individuals care or the service provided. Staff told us they felt unable to raise creative ideas to management for residents. One member of staff told us that when they made suggestions for change, these were not always welcomed and embraced by management. One person told us, "[Name of Nominated Individual] calls a meeting because he is telling us he is changing something."
- There had been no staff meetings, residents, or relative's meetings for over a year, the registered provider told us this was due the pandemic restrictions. They had not considered suitable alternatives to face to face meetings. One relative told us "The service doesn't initiate any calls".

The provider had failed to seek and act on feedback of relevant people. This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Reporting of incidents, risks and concerns was unreliable and discouraged. Relatives told us they were not always informed of incidents or how the service responded to them.
- Complaints were not recorded or responded to appropriately. For example, the manager was unable to identify any recent complaints which had been made and lessons learnt from these. Staff and people in the home were able to evidence that they had made complaints which had not been followed up appropriately.

● Accidents and incident reviewing systems and safeguarding processes were not robust. We could therefore no be assured the duty of candour was consistently applied and the registered provider was open and honest when things had gone wrong.
● There was no evidence of learning, reflective practice or service improvement. The provider and the manager failed to be aware of, or understand, up to date guidance and best practice in a number of areas, including infection control, COVID-19 government guidance and medicine management.

The failure to monitor the quality of the service and comply with legal requirements was a breach of Regulation 17(Good governance) 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; Continuous learning and improving care
● The registered manager was not always clear about their role and understanding of quality performance. We identified significant shortfalls within the care and support provided.
● Staff told us that they felt the registered manager lacked in experience and skills to support them in their roles.
● Quality assurance measures were ineffective. Very few audits were in place at the time of our inspection. There was no robust or effective system in place to assess and monitor the quality of the service.
● The registered provider did not fully understand their responsibilities and regulatory requirements. There was a lack of effective oversight from the provider which impacted on the outcomes for people. A person-centred service was not provided. Thorough checks on individuals' care and quality of their daily experiences were not being completed, to satisfy themselves if the service was good. Concerns we identified during the inspection had not been identified by the registered manager or the registered provider.

The provider failed to ensure effective governance systems to assess, monitor and drive improvement in the quality and safety of the service. This is a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
● There was no evidence of promoting staff learning, reflective supervisions or practice. Staff were not supported in their roles and staff morale was low. Staff had not been provided with sufficient training to ensure they had the skills and knowledge they needed to enable them to provide person-centred care and support.
● Information to support decision making was not always accurate or in date. For example, the provider's safeguarding policy referred to legislation which was no longer in use.
● Continuous learning and a focus on improving care was inconsistent. We could not be fully assured lessons were being learned to improve care.
● People's care needs were not always regularly reviewed and where actions and updates had been identified these were not all completed. This meant information in care plans and risk assessments was contradictory and out of date and did not sufficiently guide staff on people's current care, treatment and support needs. We identified care plans and risk assessments which needed updating to the registered manager during the inspection, these had not been reviewed when we returned.

The failure to embed robust quality assurance systems and effectively operate the systems for maintaining accurate records was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The registered manager was unable to demonstrate a knowledge of regulatory requirements. One incident had not been notified to the CQC or local safeguarding team.

The failure to inform CQC of notifiable events is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of other incidents. This is being followed up outside of the inspection process and we will report on any action once it is complete.