JNS Care Holdings Ltd

Cawston Lodge

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
Cawston Lodge is a residential care home providing personal care and accommodation for up to 36 people. At the time of the inspection the home had been open six months and was supporting 17 people.

The home was a purpose-built bungalow. Not all of the home was open for use and sections of it could not be accessed for safety reasons. There were two communal lounges, a large dining room and conservatory for people to use.

People's experience of using this service and what we found
There were not enough competent trained staff to meet people's needs and staff had not been safely or equitably recruited. Risks to people's health and well being had not been appropriately assessed and mitigated and staff were not competent to administer and record how people needed to take their medicines. There was little knowledge of safeguarding and how to report concerns and as a consequence safeguarding alerts were made over the course of the inspection to keep people safe. People were unlawfully restricted for the benefit of the staff. The provider had been informed of concerns but had not taken appropriate steps to manage this and did not learn from previous mistakes. The home was clean except the kitchen which was the most used room. There were no systems in place to manage the cleanliness of the home.

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; the policies and systems in the service did not support this practice. Consent was not formally acquired from people when staff provided support. Staff had not received appropriate training, an induction or supervision to support them in undertaking their role. Referrals to professional teams were not made in a timely way to best support people, and advice given by professionals was not followed. There was a choice of food but how it was prepared and stored was not safe.

Staff were open and honest with both professionals and each other about the lack of training they had received, they were mostly caring and sensitive individuals who were upset they had not been supported. People told us, staff were caring but we found staff did not know how to deliver a caring service in line with the regulations and standards of care. People were given limited choices due to staff shortages but where choices were available staff happily provided them. People were not involved in how they received care and their feedback had not been sought.

The provider had an electronic care planning system which none of the staff had been trained to use. Care plan information was limited and was not updated when people's needs changed. Details around the equipment people needed was limited and information staff had on how to support people was not followed or not recorded as followed. A complaints procedure was in place but it had not been used effectively. Staff and the management had no knowledge of end of life care and relied on professional input

in this area which was not always available.

Limited systems for audit had been introduced less than a month before the inspection. Support provided had not been audited as it was not known how to access reports from the electronic system and paper records had not been used in the interim. More support staff had recently been recruited but the allocation of staff remained poor and staff simply did not know what needed to be done. Meaningful handovers were not completed and systems to meet regulations had not been introduced or understood. Due to the nature of concerns the provider was issued with an urgent notice of decision to take immediate action. Information requested by the commission was not received and the provider chose to close the home.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
This service was registered with us on 9/05/2019 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about staff culture, levels and competence of staff and the care provided, including the administration of medicines and meeting people's dietary requirements. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to all of the regulations inspected. We found breaches in relation to staffing and their recruitment, the safe management of risk and handling medicines, identifying and responding to safeguarding concerns including when people were at risk of neglect and unlawful restrictions. There was a lack of knowledge around people's dietary requirements and supporting people at risk of malnutrition and dehydration, a lack of person-centred care, people's dignity was not upheld and the building had not been decorated or designed to meet the needs of people living there. We found the complaints procedure had not been initiated when complaints had been received and a lack of governance and oversight meant the same concerns reoccurred.

Follow up
During the inspection the Local Authority cancelled the commissioning contract with the provider and the Care Quality Commission served an urgent notice of decision restricting the further admission of new people to the home. Continued failure to address concerns led to the provider taking the decision to close the home and people were placed in the care of a different provider

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?

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.

Cawston Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was completed by two inspectors and one assistant inspector.

Cawston lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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, but they were no longer in post when the inspection started. An acting manager was in post who also stopped working at the home before the inspection was completed.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Prior to the inspection we reviewed the information we held about the service and were in contact with the Local Authority quality team who were working with us to improve the service. We were also supported by the Clinical Commissioning Group who was visiting the home regularly to ensure people were safe. This information helps support our inspections.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with 15 staff or people nominated by the provider to be responsible for ensuring the service improved. This included the nominated individual, the acting manager, the deputy, senior carers, carers, consultants, the chef and activity coordinator. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with five people who used the service.

We spoke with six visiting professionals including the manager from the quality team, the clinical lead from the local clinical commissioning group, social workers, district nurses and other health care professionals.

We reviewed six people's care files in more detail and reviewed other people's records to ascertain if certain information was available including capacity assessments and medicine care plans. We looked at three staff personnel files in detail and checked in others to ascertain if application forms, interview notes and induction information was available. We also looked at other management information to ascertain how the provider was monitoring the service was effective in its aim and was meeting the needs of the people living in the home.

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.

After the inspection
We continued to speak with the consultant and nominated individual to assure ourselves action was taken as required. We also spoke with the Local Authority to ensure people were safe as they were moved onto other services.

Inadequate

Is the service safe?

Our findings

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

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

- Local safeguarding procedures were not being followed and people were at risk of abuse.
- People were being unlawfully restricted as the staff had not received appropriate training and did not understand you could not physically encourage people to stay in one place.
- Staff supported people to chairs and then put footstools under their feet so they could not get up. When they moved their feet to get up, staff put them back on the footstool. This was also the case when people were in wheelchairs and began to move from tables. Staff would push them back to the table and put the brake on their wheelchair so they could not get out.
- When we spoke to staff about this they told us, they were keeping them safe as they needed the support of two staff. There were no assessments to support this was an appropriate method to do so.
- When people had unexplained injuries and pressure areas of grade three or above the management team had not reported incidents to the local safeguarding team.

Procedures were not followed to ensure people's rights were protected or people were kept safe from harm and potential neglect. This was a breach of regulation 13 (safeguarding people from harm) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection; Learning lessons when things go wrong

- Risks to people's health and well being were not assessed and plans were not developed to mitigate them.
- When people had accidents or were involved in incidents, accident information was not always recorded. Details were not handed over from one shift to the next and people were not monitored to ensure they were safe.
- People had developed pressure sores from lack of mobility. These were not risk assessed and body maps were not completed to monitor improvement or deterioration. When guidance was given to frequently reposition people it was not always followed.
- When people's behaviour changed staff were not aware of potential reasons, including potential for urinary tract infections. Three people were diagnosed in one weekend by the clinical team visiting the home. Records showed people received insufficient fluids to reduce risks of infection.
- The service was opened six months prior to the inspection and all fixtures, fittings and furniture were new at that time. However, cleaning schedules were not in place and one we were given for the kitchen was not accurately completed. The kitchen was not cleaned in line with the schedule and worktops and equipment were dirty.
- Staff had not been trained in food safety and food was not handled safely including how it was defrosted,

stored and served. This meant people were potentially at risk of bacterial infections caused by eating food which had not been treated safely.
● Concerns were shared with the provider approximately eight weeks prior to the inspection and the Care Quality Commission (CQC) and Local Authority had met with the provider's representative to discuss improvements required. The provider did not adopt safe working practice even when concerns were shared with them by professionals.

Risks were not managed which placed people at risk of harm. Food was not handled safely and the provider did not manage risks better when issues were shared. This was a breach of regulation 12 (safe treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were not enough staff to keep people safe and support their autonomy, independence and deliver care in line with their needs.
● A tool was used to determine staffing required to meet people's needs. However, this was based on insufficient or incorrect information.
● People were regularly left unsupervised on the first day of the inspection. This improved on the second day but staff without sufficient induction, training or knowledge of people were tasked with supporting people, which was not safe or appropriate.
● People were often supported by one staff member when two were required. This included support with their mobility and when people presented staff with behaviour that challenged them.
● Due to a lack of supervision, an inspector had to intervene when a person went into another's bedroom, causing them distress. The person exited the room with a glass of thickened fluid and staff did not know what or whose it was. This meant one person had not received the drink that they should have and potentially a person had drunk a fluid which they should not have.

There was not enough staff to safely meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were not safely recruited, checks were not routinely made to ensure staff were suitable to work with vulnerable adults.
● Recruitment files did not contain application forms or interview records. Some had been completed after staff had been working at the home for some time.
● When we asked for evidence of all staff's DBS information it was not provided.
● No one had a contract of employment and posts were not advertised. Staff were recruited to post following recommendations or telephone conversations.
● Staff were recruited to clinical posts without any clinical experience and only basic social care qualifications.
● Information was not available as required in schedule three of the regulations. This includes a photograph of the person and a full employment history.

When staff are not safely recruited this is a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Staff were not trained in the safe handling of medicines. Putting people at risk of not receiving their medicines safely.

● Records for administering medicines had gaps in them which could not be explained, the records showed medicines had run out of stock for five people and was not replaced.
● There were not any staff available through the night who could administer medicines which meant people went without 'as required' pain relief medicine. Following the receipt of the Notice of Decision the provider ensured agency staff trained in medicine administration were on shift at night.
● Antibiotics were prescribed for illness and were not administered in a timely way, including doses missed.
● The home ran out of paracetamol and when one person became poorly it was not available.

Medicines were administered by untrained staff and mistakes were made, people did not always receive their medication as prescribed, this is a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- The provider had taken over 10 people into the home at very short notice. Their needs had not been assessed and care plans had not been developed to determine their needs. People were at risk of receiving inappropriate and incorrect care.
- The week prior to the inspection one person had fallen ill and a GP had been requested. When the GP attended, staff were asked if they had a DNACPR in place and staff had said no. When this was questioned it was found the person did have a DNACPR in place. The provider had developed a system where by the frame of a picture to the person's bedroom was a certain colour if a DNACPR was in place. The frame on the door of the person depicted one was not in place which was incorrect. This person was at risk of life saving treatment they did not want or could receive safely.
- The provider did not have a standard set of policies and procedures which were up to date and followed when delivering the service. This included procedures around care planning and risk assessment. People had not received an assessment prior to, or immediately after admission, to ascertain if the home could meet their needs and people were inappropriately placed.
- People were not in receipt of good quality care. Professional teams were supporting the home due to the identified risks to people's health and welfare.
- When professionals gave advice to the management team on how best to support people this was not followed. This included the completion of charts to monitor behaviour, wounds and food and fluid intake. This meant the effectiveness of support provided could not be measured and adjusted to meet people's needs.

People's needs were not appropriately assessed and were not met. Professional advice was not routinely followed. This placed people at risk of harm. This 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 had not received induction to their role, had not received appropriate training and were not supported by way of adequate supervision and team meetings. Staff did not have the experience to deliver adequate care and support to the people in the home.
- Staff told us they were asked to work independently without an induction. On the day of the inspection, the senior allocated a staff member to support people without supervision. They also allocated another staff member who had just started to work on the rota as a second staff member to support people who needed

two staff to support them. The inspector intervened to ensure staff were allocated to safely support people in the home.
● Senior staff were administering medicines without their competence being tested by a competent person. After concerns were raised a visting clinical health professional observed a senior staff member administering medicines and determined they were not competent.
● Staff had little knowledge of how to support people who lacked capacity and people were frequently restricted without lawful authority.

People were at risk of unsafe support because staff were not supported to be competent in their role This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were at risk of not receiving nutrition that met their needs. They did not have nutritional care plans in place and those with specific diets were not suitably catered for including diabetics.
● One person told staff they thought their blood sugars were low and were beginning to feel unwell. Staff did not know what to give the person. There was not anything available that was suitable and the person was given what was thought to be the best option from what was available.
● There was not a record of people's weights, the food intake for those at risk of malnutrition was not effectively monitored and staff were not monitoring what people drank effectively or safely. As noted above one person's thickened drink was taken by another person.
● Professional teams took action to develop nutritional care plans for everyone in the home to ensure they were kept safe.

When appropriate steps are not taken to support people with their nutritional needs there is a risk needs will not be met. This was a breach of regulation 14 (Meeting nutritional and hydration needs) 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 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.
● There were people living in the home with limited and fluctuating capacity who had not been assessed under the MCA to ensure their needs were lawfully met.
● Applications had not been made for DoLS when people's movement was restricted. There were doors internally and externally which were locked by a key code. Assessments had not been completed to determine whether these areas could and should be accessed independently or not. This meant people's movement was unlawfully restricted.

● Where people's capacity was fluctuating, decisions had not been formally made in their best interest when required. This included when people wanted to eat food that was not recommended because they were diabetic, when they received visitors which caused them distress and lack of access to a call bell because a sensor mat was being used instead.
● Assessment was required to determine if people were aware of the risks to certain situations and could consent to them or not. If not, then decisions should be formally made in their best interest to keep them safe.
● Formal consent had not been acquired for people who were able to give it. Records of consent had been signed by the previous registered manager.

When people's consent is not sought in line with guidance and best practice, people may not receive the support they want or need in a way they have chosen. This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The home was freshly decorated to a high domestic standard. However, consideration had not been given to the people supported in the home. There was limited signage to help people independently move around the home and some areas were not accessible.
● People were supported in the conservatory which did not have a television. Staff told us people tended to stay in the conservatory during the day. However, we saw staff move people to the conservatory after meals. The large lounge area was only accessed by those who were independently mobile and we never saw the television on, to be watched by people if they wanted.
● The home was decorated all white and people had difficulty finding their room. There was no distinction between one corridor or another and people appeared to move around without purpose.
● We discussed the environment with the acting manager. They were unaware of any research or best practice guidance on how to decorate a home or how the use of orientation tools or signage could help support people with purposeful movement.

The buildings decoration had not considered the needs of the people the building supported, the design of the home was not being utilised to support the people living there. This was a breach of regulation 15 (premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- Staff were unable to support people with their specific needs as these were either unknown or staff had not received specific training. People's dignity and autonomy was not upheld and independence was not promoted.
- Some people in the home presented staff with challenges including people living with dementia and with mental health needs. Staff were visibly fearful of some interactions with these people due to a lack of specific knowledge.
- There were no records of when people had received a bath or shower and we noted one bath was not in use. Some people looked clean and tidy but some did not. Gentlemen were unshaven and there was no evidence to show this was their choice.
- Assessments of people's continence needs had not been completed and a provider's supply of continence aids was being used when staff thought they were required.
- As people were all supported in the centre of the home the toilet in the main reception area was mostly used. This meant anyone waiting in reception could hear staff supporting people in the toilet.
- Staff referred to people as a 'one' or a 'two', meaning how many staff were required to support them. We frequently heard staff requesting support because "[person] was a two."
- When eating some people made a mess. Staff seemed unable to register people may need support to keep clean and eat their meal in a more dignified manner.
- A person went to get up and leave the dining room and staff encouraged them to stay. When asked why, we were told they had been told to keep everyone in the dining room until staff had finished getting everybody up for the day.
- People were occasionally asked if they would like to do a particular thing but mostly staff directed them to places. This mostly included from the dining room to the conservatory and back to the dining room. These rooms were next to each other, only on one occasion did we see the large lounge used and we were told it was not used regularly.
- There was not a formal or informal feedback route for people to share their views on the service they received.
- Drinks were not accessible to people in the home without staff getting them. A family member had bought in an urn for hot water and tea and coffee for people. The acting manager had put this on the side in the dining room. However, there were no available cups on one afternoon so people could not use it if they wanted too. We asked if there was a risk assessment for use of the urn and was told there was not.

People's autonomy, independence was not encouraged, staff did not treat people in dignified and respectful way. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were open and responsive to support and direction when provided but had not received the training they needed to meet people's needs in a dignified and respectful way.

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- An electronic care planning system was being used but staff did not know how to use it. Care plans had not been developed accurately and had not been updated with people's current needs. Staff did not have the information they needed to meet people's specific and individual needs.
- Records did not include basic information about people's care needs and how they should be supported. This included information around catheter care, dementia, pressure care and mobility.
- One person who was supported with a day and night catheter. When we attended the home early one morning we found the night catheter bag was not in situ. Not all staff knew how to change the catheter. The day bag was full and backing up and was causing distress. When staff were informed they attempted to empty the bag, the bag had not been fitted correctly and urine leaked onto the floor when being emptied.
- Where people were living with dementia and other mental health needs, staff were unaware on how to support them. Advice had been given by professional teams on how to monitor behaviour. This would help the identification of triggers and provide information to develop a plan to reduce associated risks. The acting manager had not ensured the records for monitoring behaviour had been completed and monitored. The mental health teams had to use their own limited evidence from their visits and previous knowledge of individuals to best support people.
- Staff did not know how to support people with pressure care, when repositioning had been advised it was not recorded as being completed. Body maps were not completed and used effectively and clinical support teams worked from their own records to ensure people were safe.
- A number of people were supported in wheelchairs or with mobility aids. Some required the support of hoists or stand aids to mobilise. Basic assessment of what support was required had not been completed. There was only one convenience sling with both items of equipment and these were not the right size for all people.
- We discussed all the above concerns with the acting manager, who did not take responsibility for issues raised. However, they were responsible for a lack of action being taken since they came into post approximately three weeks prior to the inspection.
- A person had died the week prior to the inspection. We reviewed their records and found end of life care planning was not in place. Clinical teams were on site and noted deterioration in the person's health and shared with staff the person was end of life. No information had been recorded in their file. When we looked at information for another person of the same name it noted they were end of life and they were not. Staff had written this key information on the wrong care record.

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.

● There had been no action taken to support people in understanding their care needs. There were no pictorial cues used to support people with making choices around their care, when they were unable to understand the choices presented.

● Staff were unclear on how to best communicate with people whose capacity fluctuated. This was specifically noted when activities were taking place. There were not any tools to support staff in engaging people in activity that was meaningful.

Personalised and accurate care planning and records of the support provided were not in place. People were getting inappropriate care. 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

● A complaints procedure was on display on the notice board. However, when people raised concerns the procedure was not followed. The provider did not have an accurate record of complaints made and if they had been resolved. This meant the provider did not have key information to drive improvements.

● The complaints folder held one complaint. The complaint response stated raised a safeguarding and notified CQC. However, there was not a response to the person making the complaint.

● We were aware of four complaints which we had been told had been raised with the provider. None of these were in the complaints folder.

● On the day of the inspection a family member complained about a lack of staff. We discussed this with the acting manager who told us the family member regularly complained. But none were recorded.

● One complaint made included access to drinks. This had been resolved by the placement of a drinks urn. This was also not in the complaints folder.

The provider did not receive, record, investigate and respond to complaints appropriately. This was a breach of regulation 16 (Complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● An activities coordinator had recently been appointed to the home and undertook daily activities. We saw people engaged with the activity coordinator when they were able. However, those less able did not have any stimulation. There was not a television in the room where people were sat during the day.

● Arts and crafts had begun to take place in a dedicated craft room and we saw items that had been made including arranged flowers and pictures.

● The activity coordinator was beginning to develop information on people's likes and dislikes and told us they had a plan to deliver more one to one support for those who were unable to take part in group activities.

Inadequate

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

- The inspector had been in contact with the previous registered manager and nominated individual to share concerns prior to the inspection. We were told steps had and would be taken to drive improvement. Following the start of the inspection the provider was issued with a letter of intent to take urgent action as steps had not been taken and serious concerns were found.
- The provider responded, as requested, and told us the action they had taken. When we returned for the final day of inspection we looked to see if the action stated in the response was being implemented, to ensure people were kept safe. We found it had not.
- We were assured staff would receive immediate competence tests to safely administer medicines and they had not. We were assured staff would receive immediate training to use the care planning system, they had not.
- Safe recruitment procedures had not been followed and when we identified this prior to the inspection, the provider employed a person they had recruited to deliver training as the acting manager. This exasperated a culture of poor management. When we reviewed the competence of the acting manager we found they were not qualified to deliver the training they were recruited to do.
- There was not a suitable and up to date set of policies and procedures for the staff to use as guidance when delivering the service.
- The provider had supplied the Care Quality Commission (CQC) with incorrect information and assurances given were not reflective of practice. The CQC issued a Notice of Decision to take urgent action to keep people safe. Included within that notice was a requirement for the provider to share certain information with the CQC. This information was not shared. The provider chose instead to work with the Local Authority to close the service.

The provider had not ensured that staff at all levels worked within a culture of openness and transparency. Policies and procedures were not in place to support this practice. This is a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
Working in partnership with others

● The registered manager had recently been dismissed from their employment. An acting manager had been in post for the three weeks prior to the inspection and stopped working prior to the conclusion of the inspection. Some action had been taken in that time to drive improvement but not enough to ensure people were safe.
● There were no governance procedures in place to assure the provider, people were in receipt of a service that met their needs. The acting manager and most of the staff were unsure how to use the electronic care planning system and information added was inconsistent and at times inaccurate.
● Quality assurance systems were not in place as the acting manager could not access reports from the electronic monitoring system to either determine if any changes needed to be made to the support provided.
● Minimal audits had begun to be completed in October but only one of each kind was in place, so ascertaining if any action required had been completed could not be done from the audits available. All audits we looked at did not identify the concerns identified by the CQC, which questioned their effectiveness.
● The Local Authority quality team had been visiting the home and completed an action plan with the provider to drive improvement. The action plan was not used by the acting manager to support decisions made. For example, greater urgency was given to the employment of a hairdresser than to updating care plans identifying people's care needs.
● People were not involved in the decisions taken in the home. There were not any resident or relatives forums to gather formal feedback from people. Questionnaires and surveys had not been used since the home opened to ascertain if people were happy with the support they received.
● There were not any risk assessments for the health and safety of the building and its use. Consideration had not been given to the risk associated with supporting people living with dementia, mobility issues and mental health needs that at times presented behaviours that challenged staff.
● Professional teams had been on site supporting the service for approximately three weeks prior to the inspection. Advice they had given to staff on site was not always acted upon or shared. Handover records and procedures were poor and information was not passed from shift to shift. This left people at risk of not receiving the support they needed.
● One person had an infection and was administered antibiotics. Night staff were unaware of this and they were not administered as directed by the clinical team.
● Directions were given for samples of bodily fluids to be taken to GPs and these were not followed or samples were not taken in a timely way, making them unsuitable for testing.

There were not appropriate and effective systems for governance and oversight. Monitoring was not fit for purpose and records were not contemporaneous and often not accurate. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Notifications had not been received as required by the commission. This included where safeguarding alerts had been made and where people had been admitted to hospital following accidents and incidents. Some of which were unwitnessed.

This provider had not shared information with the commission by way of notifications. This is a requirement of their registration and placed people at risk of harm. This was a breach of regulation 18 (Notification of other incidents) of the Health and Social Care Act 2008 (Registration) Regulations 2009.

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 Notifications were not received as required in line with the registration. 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 were not involved in developing assessments of their support needs. People were living in the home without appropriate and accurate assessments of their care needs in place. Regulation 9 (1) (2) (3) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's autonomy and independence was not encouraged and respected. Questions had not been asked to determine people's preferences and people were not treated in a way that respected their choices. Regulation 10 (1) (2) a, b, c

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not acquired from people prior to service delivery. People did not always have the option to refuse support. The principles of the Mental Capacity Act had not been implemented. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Procedures were not in place to ensure people received nutrition and hydration in a way that met their needs. When people were at risk steps were not taken to ensure they received enough nutrition and hydration. Regulation 14 (1) (2) a

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Consideration had not been given to the design and decoration of the home in line with people's needs. Regulation 15 (1) c

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not received, recorded, investigated and responded to in an effective way and in line with current best practice guidelines and the requirements of the regulation. Regulation 16 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet people's needs. tools were not in place to determine the skills and mix of staff required to meet people's needs. Staff did not receive appropriate training and support to deliver an effective service. Regulation 18 (1) (2) a, b

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not safe, Their needs and associated risks had not been assessed or mitigated, medicines were not safely administered by competent staff. Risk of infection were not managed and equipment was not provided as required. Regulation 12 (1) (2) a, b, c, f, g, h

The enforcement action we took:

Urgent Notice of decision already issued to restrict admissions and NOP to be issued to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were unlawfully restricted without appropriate assessment under the Mental Capacity Act. Procedures were not in place to protect people from harm and safeguarding referrals were not made as required. Regulation 13 (1) (2) (3) (4) b (5) (7) a, b

The enforcement action we took:

Urgent Notice of decision already issued to restrict admissions and NOP to be issued to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have a system in place for governance and oversight, audits were not completed to ensure standards in service delivery were acceptable People were not asked if the service they received was in line with their needs and preferences. Records of the service delivered

were not held in a contemporaneous way.

Regulation 17 (1) (2) a, b, c, d, e, f

The enforcement action we took:

Urgent Notice of decision already issued to restrict admissions and NOP to be issued to cancel registration