Nexzen Care Ltd

The Cedars

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

Summary of findings

Overall summary

About the service
The Cedars is a residential care home that provides accommodation and personal care for up to 28 older people. People who live at the home access nursing care through the local community healthcare teams. At the time of the inspection 20 people were living at the home.

People's experience of using this service and what we found
There were widespread and systemic failings identified during the inspection. The quality and safety monitoring systems used by the provider were not fully effective in ensuring the quality of service provision and mitigate risks to people. This did not ensure people were treated with kindness, dignity and respect.

At the time of inspection there was no registered manager in place. There were also not enough suitably qualified staff to ensure people received safe and effective care. People did not receive adequate levels of personal care. Care was delivered in an institutional way.

Staff training was provided but was not always completed by staff before they started work. Training did not ensure people's specific needs were covered. Staff recruitment procedures were not followed appropriately. Staff had not received regular supervision.

The provider had failed to make appropriate statutory notifications; notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. Safeguarding incidents had not been identified and reported.

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 systems in the service did not support this practice.

Care plans did not contain sufficient information to ensure people received person centred care. The guidance within peoples' risk assessments were not always followed by staff and records used to monitor peoples' health were not always completed. This exposed people to risks unsafe or inappropriate care or treatment.

The provider had not provided people with person centred activities and access to the local community. The majority of people stayed in their rooms all day.

Procedures and records for the administration and the safety of medicines were not completed effectively.

The environment was not maintained effectively; there was an infection control risk to people using the service. Fire risk had not been appropriately managed.

People had access to healthcare professionals.

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 14 July 2021 and this is the first inspection.

The last rating for the service under the previous provider was Requires Improvement, published on 18 April 2020, the service was in special measures. The service has deteriorated to Inadequate.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the key question sections of this full report.

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

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

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to staffing, safeguarding, need for consent, recruitment, safe care and treatment, person-centred care, nutrition and hydration, dignity and respect, governance and notifications.

Follow up

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

Special Measures

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this 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?

Requires Improvement

The service was not always 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.

The Cedars

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by three inspectors; two inspectors attended on each day of the inspection.

Service and service type
The Cedars is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Cedars is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used information gathered as part of monitoring activity that took place on 18 May 2022 to help plan the inspection and inform our judgements.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with nine people who used the service and one relative about their experience of the care provided.

We spoke with seven members of staff including the 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 range of records. This included four people's care records and medication records. We looked at four staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one professional who has visited the service.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

● Risk assessments lacked relevant information. We looked at the plan for one person who had epilepsy and who was at risk of seizures. The plans did not provide staff with enough information of what to do in the event of a seizure to keep the person safe
● Staff did not always demonstrate knowledge of people's medical conditions and how to mitigate risk. For example, we asked one staff member how they monitored one person's blood sugar levels for their diabetes. The staff member said the blood sugar levels were recorded and we saw records of this. However, the staff member was unsure what to do if the levels were consistently high or if the person refused their medication.
● There was a failure to identify choking risk. One person was on a pureed diet due to choking risk there was not however any associated risk assessment. We also observed that people at risk of choking were not assisted to eat using the correct spoon.
● The provider failed to act and undertake works to improve environmental safety. There were numerous examples of this such as a failure to undertake an annual fire risk assessment. Checks associated with Legionella had not been undertaken. In addition, fire door checks had been undertaken by a person who had not received any fire training or training to enable them to understand what was required.
●The fire service and environmental health had both issued the service with actions for improvement.
● The temperature of the clinical room was not always monitored daily however when monitored even early in the day, the temperature of the room was running close to 25 degrees centigrade despite it not being a very warm day. This is the upper limit that manufacturers recommend medicines are stored at. There was an air conditioning unit in the room, but this was not being used.
● Medicines records were not accurately maintained. We observed a staff member administer two doses of a controlled drug which had not been signed as witnessed by a colleague. When we brought this to their attention, they said they would get a colleague to sign later and did not appear to fully understand their responsibilities around management of controlled medicines.
● Staff medicine competencies we looked at, did not evidence that staff had been fully assessed on their abilities to administer medicines safely.
● Staff had transcribed instructions onto medicine administration records (MAR) sheets but had not consistently signed them. This meant there was a risk that staff could hand write the incorrect medicine administration instructions and other staff would administer incorrectly.
● There were gaps in MARs where staff had not signed to confirm they had administered medicines as prescribed. There were also no running stock balance checks which meant there was a risk that people did not always receive their medicines.

● Topical medication records had not been consistently signed by staff and transdermal patch records were not completed fully. This meant it was not clear if people always had these medicines as prescribed.
● Some people had been prescribed additional medicines on an as required (PRN) basis. Protocols were in place; however, these had limited information for staff to inform them when people might need them.
● Medicines had not always been dated when opened. This meant it would be difficult for staff to know when items had expired.
● The provider had failed to ensure that measures to protect people from COVID-19 were being adhered to. On the first day of inspection the inspectors were not asked to show their COVID-19 LFT results. This is not in line with the latest government guidance for professionals visiting a care home. On the second day of inspection the same happened until it was raised with the manager.
● There was a COVID-19 policy in place; however, this was dated October 2021 and did not refer to the latest government guidance.
● Not all staff had completed infection control training.
● There were multiple concerns around state of repair of the building, fixtures and fittings which meant it would be difficult to reduce the risk of spread of infection and keep the service clean. For example, there were many wipeable chairs around the service that were worn through to the foam. Flooring in bedrooms was worn in places which meant it would be difficult to keep clean. Tiles and flooring in bathrooms were dirty and damaged.
● Daily cleaning schedules were in use and were signed by the cleaning staff daily. However, the cleaning staff levels meant it would be difficult to maintain the cleanliness of the building.
● Signs in bathrooms and care plans prompted staff to monitor the water temperature. We asked to see records of water temperature testing but were informed none were available.
● The clinical room was untidy and looked visibly unclean.
● Not all staff had short unpolished nails as required for good infection control practice particularly when delivering personal care.

The provider failed to manage and assess potential risks to people and consistently manage medicines safely. This placed people at risk of avoidable harm. These shortfalls were 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
● Visitors were asked to complete a COVID-19 lateral flow test before each visit. However, this is not current guidance. The provider did not seem aware that visitors did not require testing prior to visiting.

Staffing and recruitment
● The provider failed to use a systematic approach to assessing staffing levels. The staffing dependency tool used to assess staffing did not take into account the layout of the service, peoples' needs for physical assistance, peoples' needs for activity and engagement and the additional catering and cleaning duties required by care staff when domiciliary staff were not on duty.
● Cleaning staff were employed at the service but covered the daytime hours up until 12:30pm or 2pm most days. On some days there was cover until 3pm. We observed that there were areas of the service that were visibly unclean after the cleaners had left.
● People told us there were not enough staff, one person said "We need more staff. It would be better if we had more staff. They come in their own time" and "There are so few staff". Another person said that their call bell had not been left within reach. Staff also made comments stating; "We have no time to sit with people or take people out" and "We've been on [three staff] since…. We were told that's all we need. Where [The provider] got the information from I don't know". And " There is no time to do anything beyond the basics."
● We saw staff took a task orientated approach to care completing essential care tasks but not spending any

quality time with people. By the time staff had completed morning personal care and breakfasts they then went on delivering drinks and then it was lunchtime. In between they were writing up care notes and answering call bells. The afternoon was very similar after lunch and staff were rushing from one person to the next with no time in between to spend with people other than passing comments.

● People were not always well treated in respect of their social and emotional needs due to a lack of staff. There was very little interaction seen between people and staff. Staff did not sit and talk with people for a meaningful length of time as they were task orientated. For example, people who could not leave their rooms did not have any companionship to ensure their needs were met. We saw people looking for staff support during the inspection. We also saw people asking for staff attention to be told "There's only two of us you'll have to wait".

● People told us they were unable to undertake their hobbies such as sugarcraft or visit the library because there were not enough staff. One person said that staff were never able to give them their personal care in time for when they're relatives visited despite repeated requests. This impacted their ability to go out with their relatives.

The provider failed to ensure sufficient numbers of suitably qualified staff were deployed across the service. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We looked at the recruitment records of four staff. Each record had not been robustly checked. There were multiple gaps in previous employment on staff application forms which had not been explained. One application had work history which was dated in the future in more than one area. This had not been identified or questioned by the provider.

● Inappropriate references had been sought from applicants' friends or ex colleagues rather than their last employers in health and social care

● Right to work checks for internationally employed staff had not been properly documented.

The provider failed to ensure that staff were recruited in line with legislation. This was a breach of regulation 19 (Fit persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● All staff had enhanced Disclosure and Barring Service (DBS) checks. DBS checks ensure that people barred from working with certain groups such as vulnerable adults would be identified

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

● There were systems and policies in place to safeguard people from abuse however these had not been used when safeguarding events had occurred.

● There was a failure to safeguard people. Incidents relating to people of alleged abuse and neglect of care support had not been reported as required to the local safeguarding authority in line with legislation.

● There was a failure by the provider to understand and learn from incidents. For example, there had been an incident whereby staff had served undercooked meat products to people; there was evidence of this. This incident had not prompted the provider to ensure the staff involved had food hygiene training and understood the importance of ensuring meals were checked and probed before service. This incident had also not been recorded as an incident to learn from. We were not assured the provider understood their responsibility to ensure all incidents were recorded, investigated, and learnt from.

The failure to safeguard people by not reporting potential abuse, amounted to a breach of Regulation 13 (Safeguarding service users from abuse and improper 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 and support

Staff support: induction, training, skills and experience

- The provider failed to ensure staff received training relevant to their roles. We reviewed the current staff training matrix. We found staff had not always undertaken the provider's mandatory training. For example, not all staff that had worked in the kitchen had undertaken food hygiene training or safer food better business which are food safety management procedures and food hygiene regulations for small businesses. These staff had been cooking in the absence of a chef.
- Staff were not supported to access training that was specific to peoples' support and health care needs. For example, some people had health conditions which required additional training of staff including diabetes and epilepsy. A member of staff who was testing blood glucose levels did not know what to do when blood glucose levels were outside the normal range. In addition, staff had not been trained in what to do should a person have a seizure. The training matrix showed that although senior care staff had completed diabetes training none of the care staff had. None of the staff were listed as having completed epilepsy training.
- Staff were training each other in the use of equipment such as hoists without the necessary qualifications.
- The provider's policy stated that staff should receive a minimum of six supervisions a year; this had not happened, and staff had not been receiving regular supervision since the last registered manager had left the service. Some staff had received one recent supervision but none in the previous ten months this included staff who were new to the service. Some new staff had not been effectively supervised in their role to assess competency and any needs for learning and development. We referred one member of staff to the provider due to errors in medicine practice

The provider failed to ensure staff had received training and supervision required for their roles. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Consent to care was not always sought in line with guidance and legislation. There were no decision specific mental capacity assessments and best interest decisions in relation to care for people who were unable to consent. Staff had recorded that people's relatives had consented to various aspects of peoples care however there was nothing to show how the specific decision had been reached or whether people had been consulted.
● Decisions were not always made in the best interests of people for example consent was given for people's photographs to be used in public areas and for the provider's purposes however it was unclear how this could be assumed to be in people's best interest.
● There was a failure of the provider to uphold people's rights by allowing them to believe that COVID-19 prevented them from dining socially and leaving the service for activities.
● The provider had not ensured that DoLS applications had been followed up for review. We were not assured that all people that may require DoLS had DoLS applied for.

The failure to ensure that peoples' rights were upheld in line with Mental Capacity Act legislation was a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● There had been a long period of time when the service had been without a chef on the weekends. A new weekend chef was due to start at the service soon. In the absence of a chef a mixture of meals had been provided by staff who were not adequately trained in food hygiene and nutrition.
● A person who required a specific diet for medical reasons had not received this diet; this had had a negative effect on their medical condition. This had been confirmed by the local authority safeguarding team.
● A new weekday chef had also been appointed and was improving the menu to people to include peoples' likes and dislikes. People gave mixed views of the food some said it was very good, others said the portions were too small. Another person said they wished to have more food from their own culture, and another said there were too many sandwiches served. Staff said, "Every Sunday we used to have a roast. This isn't happening anymore. This is their [Peoples'] home, they should have what they want" and "[People] are not happy with the food, they are all complaining."
● People who ate mashed food did not receive the separate parts of their meal as separate mash shaped to imitate the food that had been mashed. All parts of the meal were mashed together; the result did not resemble an appetising meal for people. People would be unable to taste each part of their meal individually. We observed one person being assisted to eat a mashed meal. We asked what the food was, and the staff member didn't know. This meant they had not informed the person of what the meal was.
● People had access to drinks throughout the day and we saw that people who stayed in their bedrooms had a drink close by however we were not assured by records that people who could not drink independently received adequate assistance. For one person who was having their fluid intake monitored records showed that on one day they were not provided with a drink for over 14 hours and there were other lengthy gaps between drinks. This did not show that this person had enough to drink during the day.

The provider had failed to ensure people had access to suitable nutrition and hydration that met their needs and preferences. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider had placed a person in a bedroom that had little ventilation, was dark and had a frosted window with no view. There had been no consideration to the temperature in the room which was very warm on the days of inspection despite it not being a very warm day and how the room may affect the person's mental health. The room was also very noisy as it was sited just off a communal part of the home. The provider told us they would meet with the person to discuss a change to their bedroom.
- There were few adaptations to support people living with sensory impairment or dementia to navigate around the home.
- There was a dining room in the service which on the two days of inspection was only used by staff. We asked staff why people did not eat in the dining room and were told by staff "Because of COVID", however there was no COVID-19 in the service. There was no effort made to encourage people to use the dining room and most people ate meals in their bedrooms apart from approximately three people who were sat in the lounge.
- People's bedrooms contained things important to them.

We recommend that the provider reviews the environment to ensure that people living with sensory impairment or dementia have necessary adaptations.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Care assessments identified people's needs but were not up to date. Staff did not have full information on how best to meet these needs and people's choices in line with best practice guidance This meant staff did not have the guidance to ensure they provided appropriate and person-centred care. There is further detail about this in the safe and responsive sections of this report.

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

- People had access to ongoing health services. Records showed staff contacted the GP for advice. People had their health and support needs reviewed by a speech and language therapist (SALT) for example. We were not however assured that staff always knew when they should follow up on health concerns due to the lack of training.
- Staff supported people to attend medical appointments if needed.

Requires Improvement

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires improvement . This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

● People had become accustomed to accepting institutionalised care as normal. For example, people living with dementia were woken and given personal care by night staff to reduce the burden on daytime staff. This was not documented as peoples' choice and was allocated on the staffing tool to enable the staff to manage their workload.
● People's autonomy was not supported around their choices of care. People were allocated a bath or shower day and did not have a choice of when they could bathe or shower. We saw that people had signs attached to their wardrobes that stated, 'Your shower day is on a [assigned day]'. Over the two days of inspection the bathrooms were not used. One person said, "I can have a bath or shower once a month or it could be two months. It's not my choice. They say a wash down is the same". Some staff also failed to understand that an assigned shower or bath day was an institutionalised approach to care. One staff member commented "Everyone has a shower day. Once a week. There is a list of who has a shower that day."
● The provider failed to promote peoples' independence. There was no effort made to encourage or assist people to do activities that promoted their independence. One person told us how they used to spend most of their time hiking and walking outdoors but was unable to go out with so few staff. When asked the provider stated COVID-19 had prevented people from having access from the local community however COVID-19 restrictions had been lifted and the service had not been in outbreak throughout the COVID-19 pandemic.
● Some people had not been told that they were able to go out and that COVID-19 restrictions had been lifted. One person said, "I did not know I could go out".
● People were not always well treated in respect of their social and emotional needs due to a lack of staff. There was very little interaction seen between people and staff. Staff did not sit and talk with people for a meaningful length of time as they were task orientated. For example, people who could not leave their rooms did not have any companionship to ensure their needs were met. We saw people looking for staff support during the inspection.
● The provider failed to ensure people were treated with dignity and respect; staff including the provider and new manager referred to people as room numbers and 'Double ups'.
● People were not involved in reviews of their care plans; the provider missed this opportunity to find out what people required of their care and support.

The failure to preserve the respect and dignity of people by supporting their autonomy, independence and involvement in the service was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- People told us that despite the lack of staffing staff were kind and caring towards them. One person said "Staff are friendly", another person said "They are very kind. I always know someone is around at night".
- People that were independently mobile told us they could have a shower when they wanted to.

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; 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

- Care plans contained some person-centred detail, but this was inconsistent and did not cover all aspects of people's care and support needs. For example, plans did contain information about people's life histories, but did not always detail all aspects of people's health needs.
- The service used an electronic care planning system. Many of the statements in the plans were generic and were in all the plans we looked at. This was not person centred. For example, plans in relation to people's dementia needs contained generic statements, such as, 'Does not recognise self in the mirror and assumes that the reflection is another person'.
- People's autonomy was not supported around their choices of care. People were allocated a bath or shower day and did not have a choice of when they could bath or shower. We saw that people had signs attached to their wardrobes that stated, 'Your shower day is on a [assigned day]'. Over the two days of inspection the bathrooms were not used. One person said "I can have a bath or shower once a month or it could be two months. It's not my choice. They say a wash down is the same". Some staff also failed to understand that an assigned shower or bath day was an institutionalised approach to care. One staff member commented "Everyone has a shower day. Once a week. There is a list of who has a shower that day."
- People did not receive care from staff of their gender preference. One person said, "I would prefer [Same gender staff] doing my care… it's a bit embarrassing having [Opposite gender staff] doing your care".
- There was no end of life care planning including for one person who was end of life. There was no end of life care plan to guide staff about how to meet their specific needs.
- The provider had not sought to re-introduce social dining, outings for people and activities post COVID-19 outbreak. The majority of people stayed in their rooms for every meal, did not access the local community or have any access to person centred activities. There were no records to show how the provider ensured activities for people who could not access communal areas.
- People who required staff support to leave the service did not have regular access to the local community. People who went out regularly, were taken by their relatives or friends. We asked a staff member if people were able to go out. The staff member could not comprehend that people may want to go out. People said, "There are so few staff they can't take me out", and "They don't take us out so often. I ask to go out, but they are busy and in a rush. You need to get out so it's extremely difficult". One person told us they were excited as they had a hospital appointment and would be going out for the first time in 17 months.
- There were no daily or person-centred activities taking place. People said, "We've not done activities for a while, they used to" and "I spend my time just watching TV". Staff said, "We have no time to sit with people

or take people out".
● People who did not leave their room had no companionship other than when relatives visited. Some people did not have any visitors. Their need for company was not being met.

The failure to ensure that care was planned and delivered in ways that met peoples' person-centred needs and people were supported to activities 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
● There had been no recent formal complaints. We asked to review the informal complaints and were told these were not recorded. We were aware that people had made complaints about the quality of food and being unable to go out. These issues had not been recorded as complaints. This meant the provider could not be assured they were aware of the issues affecting people and act on these complaints to improve the service.

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.

● Communication plans lacked information. In one person's plan staff had documented, "Can communicate including very minimal or irregular communication", but there was no explanation of what this meant. It was also documented that the person was unable to ask for help but did not provide detail for staff on how to communicate with the person and make sure their needs were known.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- When the provider had purchased the service, it had been rated requires improvement overall and Inadequate in the well led domain. The service had been in special measures. The provider had failed to improve on previous failings to ensure that quality of care and environment were of a higher standard.
- The provider did not have a background in health and social care and had failed to ensure that in the absence of a registered manager there was competent management and oversight of the service.
- We identified serious failings in relation to the safety, quality and standard of the service. These had not been identified by the provider through their governance systems and rectified as required. There were a variety of monthly checks which were not undertaken consistently. Some audits were a tick box form and any actions identified did not have a clear action plan and checks on whether actions had been completed.
- We took copies of records on day one of the inspection. When we reviewed these same records the following day, additional information had been added.
- People's care plans had not been reviewed effectively to ensure risks to people's health and welfare were mitigated.
- Records in relation to people's needs were not completed as required. The provider's quality assurance systems had failed to ensure that records such as fluids were made as required.
- There were no infection control audits that identified the levels of environmental improvement required to ensure effective cleaning.
- The provider failed to undertake an annual fire risk assessment.
- Oversight of medicine management was poor. Audits were inconsistently undertaken and were not robust because they had not identified any of the issues we noted.
- People were not empowered to lead meaningful lives; the service was not person centred and staffing levels dictated a task orientated approach.
- People were not engaged in creating strong links with the local community as they did not have the relevant staff support.
- There had been no residents' meetings since April 2021.
- There were no relatives meetings or surveys to enable relatives to collectively share their thoughts and ideas and provide feedback to the provider.
- People and staff had recently completed surveys provided by the local authority on the standard of

service, there were recurring themes from these around food, activities and staffing. There was no associated action plan to ensure these themes were addressed.
● The provider did not have effective governance systems to ensure that staff had essential training and that lessons from incidents were shared for learning for improving care.

The failure to ensure the quality of service provision through effective governance was a breach of Regulation 17 (Good governance) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Statutory notifications had not been made in line with current legislation to allow the Care Quality Commission to monitor the service. All services registered with the Commission must notify us about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled.

The provider failed to send statutory notifications about notifiable events to the CQC this was a breach of Regulation 18 (Notifications) of the Care Quality Commission (Registration) Regulations 2009

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
● We were not assured that the provider had acted with a duty of candour due to the number of safeguarding events that had that had not been notified to us and because people had not been told that COVID-19 restrictions were no longer in place.

Working in partnership with others
● The service worked in partnership with the local district nursing team, however it was clear from records that the staff did not always follow the guidance provided.
● There was no registered manager available to attend local forums or other stakeholder and partnership events.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to send statutory notifications about notifiable events to the CQC. This this was a breach of Regulation 18 (Notifications) of the Care Quality Commission (Registration) Regulations 2009

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failure to ensure that care was planned and delivered in ways that met peoples' person-centred needs and people were supported to activities. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to preserve the respect and dignity of people by supporting their autonomy, independence and involvement in the service. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure that peoples' rights were upheld in line with Mental Capacity Act legislation. This was a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to manage and assess potential risks to people and consistently manage medicines safely. This placed people at risk of avoidable harm. Thesewere a breach of regulation 12(1)(2 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 The provider had failed to ensure potential abuse was reported appropriately. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs

	The provider had failed to ensure people had access to suitable nutrition and hydration that met their needs and preferences. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure the quality of service provision through effective governance. This was a breach of Regulation 17 (Good governance) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure that staff were recruited in line with legislation. This was a breach of regulation 19 (Fit persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably qualified staff were deployed across the service. The provider failed to ensure staff had received training to meet peoples' needs and effective supervision. This was a breach of regulation 18 (Staffing) of

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