Heritage Care Homes Limited

Victoriana Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Victoriana Care Home is a residential care home providing personal and nursing care to up to 34 people. The service provides support to people who may be living with a physical disability, mental health needs or dementia. At the time of our inspection there were 29 people using the service.

Victoriana Care home is split across three floors. People have access to their own personalised bedrooms and share communal areas such as lounges, bathrooms, dining areas and a garden.

People's experience of using this service and what we found
There was ineffective leadership at the service and governance systems were not identifying areas where improvements were needed. Audits were either not in place or not effective at identifying where actions needed to be taken. A lack of manager presence at the service had allowed a negative culture to develop which did not promote positive outcomes for people. The provider was not reporting statuary notifications to the CQC in line with requirements. People, relatives and the staff team were not being asked to feed back about the service.

Risks to people were not thoroughly assessed and risk assessments lacked detailed guidance for staff to follow. These included risks relating to fire. There were numerous infection control issues at the service and the home needed some upkeep and a deep clean. Systems were not in place to review accidents and incidents to help ensure people were safeguarded from abuse. There were enough staff to support people safely, however staff were not supported to get to know people well as individuals. People were supported safely with their medicines for the most part.

People did not receive personalised care and there was not a focus on their individual likes, dislikes and preferences. Staff were not trained or knowledgeable about people's specific health conditions. People were not being supported to engage in social pastimes which they were interested in. Staff interactions with people were task based and there was little effort made to engage with people in a meaningful way. We have made a recommendation to the service around considering best practice when communicating with people.

People were not always treated with kindness and compassion and their privacy and dignity was not always respected. Staff did not always support people to remain independent if this was their choice. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

Staff did not always have the right training or knowledge to support people effectively. People were supported to see health professionals, however advice from health professionals was not always recorded in detail in people's support plans. Changes needed to be made to the environment to help support people

living with dementia to orientate. People's needs were not always reassessed in a timely manner.

Some people gave positive feedback about their care. One person said, ''I really like it here. The staff are genuine and look out for me.'' People were positive about the food and drink at the service. Some staff spoke with people in a kind way. The management team gave us some assurances they would begin addressing the issues we found at this inspection.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 27 November 2020). The services rating has now changed to inadequate. This service has been rated requires improvement or inadequate for the last two consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

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

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

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

We have identified breaches in relation to safe care and treatment, safeguarding people from abuse, person centred care, the reporting of notifiable incidents and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. 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 act in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Victoriana Care Home

Detailed findings

Background to this inspection

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

Inspection team
This inspection was completed by two inspectors.

Service and service type
Victoriana Care Home 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. Victoriana Care Home is a care home with 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 no 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 sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and six relatives about their experience of the care provided. We spoke with 15 members of staff including care workers, senior care workers, domiciliary care workers, the cook and members of the management team including 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 three people's care records and numerous medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

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

At our last inspection systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- People had risk assessments completed in areas such as risk of falls or being at risk of dehydration. However, these were not detailed and did not give staff enough information to support people safely. One person said, ''I do not think staff know how to help me with [support need]. [Staff] all do it differently it seems.''
- It was unclear what actions were taken when people needed more support. For example, one person had a number of falls, but their risk assessment was not updated to guide staff how to keep them safe. It was recorded that this person had seen a professional in relation to their falls, however advice from this professional had not been recorded or made clear in their risk assessment.
- Another person had been refusing food and drink over a continued period of time. No updates had been made to this person's risk assessment to guide staff how to support them safely, despite a professional having come to see them about this support need. A relative said, ''[Relative] has lost a lot of weight and I am not sure what is being done about it.''
- Staff told us they did not feel safe supporting some people as they felt they needed more equipment to be supported safely. Staff told us they fed this back to management however nothing really changed. The area manager assured us people's support in this area was being reassessed and had asked a registered manager from another service to support with this.
- Risk relating to fire at the service were not effectively managed. Several actions identified in a fire risk assessment had not been completed in a set time frame. The fire evacuation plan advised staff to support people in 'zones' based on the layout of the building but did not detail what these zones were. Risk assessments guiding staff how to support people safely in a fire were not detailed and contained conflicting information. For example, a risk assessment stated a person needed different numbers of staff to support them in the event of a fire.
- Staff were not clear how to safely evacuate people in the event of a fire. One staff member told us, ''I am not sure what I would do if there was a fire. Just shut the door.''
- Several areas of the service posed a risk to people. For example, there were uncovered electrical wires in some areas of the service. The lift at the service broke down frequently leaving people unable to access the ground floor of the service if they were unable to use the stairs. The nominated individual evidenced that

this was being addressed.
● The service was not clean. Some specific areas of the service such as the kitchen, one of the bathrooms and one of the toilets in particular needed a deep clean. Utensils being used in the kitchen were also dirty and not fit for purpose. One relative said, ''The building does not look great. Quite dark and dirty- I think staff could spend more time making it look clean.'' A member of the management team organised a deep clean and ordered new utensils during our inspection.
● A cupboard containing used clinical waste was left open in a communal area. People may have been able to access this. The management team put a lock on this cupboard during our inspection.
● The garden area and furniture were dirty and would also have benefitted from a deep clean. One person said, ''It's a shame as I like to be outside, but the garden doesn't make it feel like you are getting away when [garden furniture looks like this.]''
● Large waste bins, including a clinical waste bin were left open in the driveway of the service. This presented an infection control risk.
● There were several items left in people's bedroom such as razor blades which were rusty and may have presented an infection control risk.

We found no evidence people had been harmed. However, systems were not in place to assess risks effectively and put measures in place to keep people safe. The service was not clean and infection control measures were not being followed. This put people at risk of harm. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some areas of the service did look clean. One person said, ''[Staff] are always in and out dusting and mopping.''
● Despite our findings some people and relatives felt risks were assessed safely. One relative said, ''[Staff] are very accommodating and make sure [family member] is supported safely with all aspects of their health needs.''

Systems and processes to safeguard people from the risk of abuse
● Systems were not effective to safeguard people from abuse. We found several examples where injuries to people such as falls or unexplained bruises, had not been reported or investigated by the management team. This meant measures could not be put in place to safeguard people and help prevent incidents from happening again. We raised several safeguarding issues with the local authority during our inspection as a result of this.
● Actions were not taken in a timely manner when people's support needs changed. For example, a person required a reassessment of the equipment they used for moving and handling. This was not organised in a swift manner. Staff explained they felt unsafe supporting some people as a result. This did not safeguard people from abuse.
● Staff did not have a good understanding of safeguarding people from abuse. For example, staff did not know who to report concerns to outside of the service. One person said, ''I do not feel unsafe, but I do not feel totally safe either. I am OK but I know some people hurt themselves quite a lot and I am not sure [staff] are making sure something is done.''

We found no evidence people had been harmed. However, systems were either not in place or were not effective in safeguarding people from the risk of abuse. This put people at risk of harm. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite our findings people and relatives felt they/ their family member were safe at the service. One person said ''I feel safe here. There is nothing to worry about.'' A relative told us, ''I do feel [family member] is

safe and I can sleep soundly because of this.''

Staffing and recruitment
● There were enough staff to keep people safe. However, there had been a large turnover of staff recently and some new staff did not feel they had been given the time or information to support people. One person told us, ''To start with I saw all the same staff but there are lots of new faces now. I think they are kind, but they do not know me and some of them are not adept at speaking [in my preferred manner.]''
● One relative told us they were concerned about new staff at certain times of the week. They said, ''I am worried about new staff being all that is available to support [family member]. I think it stops them being able to do what they want to do.''
● The management team were unable to find evidence some agency staff and staff covering from another service had an induction at the service. This meant people were at risk of being supported by staff unfamiliar to them.
● Staff recruitment checks were completed however we found some gaps in key areas such as past employment history. The area manager told us they would address this with staff.
● People did not have to wait a long time for support and staff responded to call bells in a timely manner. One person told us, ''There are lots of different staff, but it is OK. They all help me whenever I need it.''
● The management team explained they were focusing on recruitment and had plans to make the staff team more consistent.

Using medicines safely
● Medicines were managed safely for the most part. However, audits were not effective in identifying where errors may be made. We found several examples where medicines had not been signed for correctly. The management team told us they would change the audits to address this.
● People had protocols in place for medicines that were administered 'as and when required'. These helped guide staff as to when to give these medicines.
● People were positive about the support they had with their medicines. One person said, ''I feel very assured that [staff] know what they are doing with all my tablets.''

Learning lessons when things go wrong
● There was limited evidence of incidents an accident being discussed with the staff team to support lessons being learned.
● The issues we found during this inspection did not assure us systems were in place to learn lessons when things went wrong.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience
- Staff did not feel well supported. Whilst supervisions were happening, staff told us managers did not take time to support them effectively in their job roles.
- New staff did not feel their induction adequately prepared them to work at the service. Staff also told us they had to spend a lot of time with new staff to make sure they could support people safely.
- Staff did not have training in supporting people with specific health conditions. This meant they may not have the skills and knowledge to support people effectively.
- The management team responded to our concerns by lengthening the induction for new staff. The management team also retrained staff in key areas such as moving and handling to help ensure people were effectively supported.
- People and relatives felt staff were competent. One person said, ''I would say staff are well trained and they certainly seem confident.'' A relative told us, ''I have no concerns and feel [family member] is cared for by a professional staff team.''

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
- People saw health professionals such as the falls team or speech and language therapist if they needed support. However, changes to people's support made by professionals was not recorded clearly in care plans for staff to follow. This put people at risk of receiving unsafe care.
- The management team showed us evidence care plans would be reviewed and any advice from health professionals would be recorded clearly.
- People and relatives were confident staff would contact health professionals if this support was needed. One person said, ''I am not poorly at the moment but when I am the staff make sure they call a GP.'' A relative told us, ''[Staff] are excellent and always organise the right care for [family member]. They let us know what is happening.''
- Staff supported people to be healthy. For example, by making sure plentiful food and drink was available and supporting people to exercise regularly.

Adapting service, design, decoration to meet people's needs
- Some areas of the service needed work completed or replacing. This included the lift and some of the bathroom facilities. One person said, ''The toilet facilities here are not very good and I do not like using them. The lift has broken a few times as well.'' The nominated individual showed us evidence these works were being pursued.

● The service had not been adapted to meet the needs of people living with dementia. For example, equipment in bathrooms were not coloured to help people use it. There were no signs or guidance to help people orientate themselves to their surroundings. One relative told us, ''The service is not very nice to look at- the floor rises up in the bathroom and the standard of the toilets is poor.''
● People had not been supported to personalise their bedrooms. One person said, ''I would like different colours. I certainly would not choose the wallpaper I have currently.''
● The management team assured us that plans were in place to improve the environment at the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were not always being supported in line with best practice guidance as staff did not have the training to support them with specific health conditions such as dementia. Risk assessments and care plans were not being reviewed effectively to help ensure people's needs and choices were assessed regularly. One relative said, ''We have never been asked to feed in to [family member's] care plan. It is a shame as this would be useful for the staff team.''
● One person would have benefitted from having their needs relating to moving and handling reassessed. However, this was not done in a timely manner. One person told us, ''I know I could do with [a new piece of equipment] but I am still waiting for this.''
● The management team organised training in specific areas for staff following our inspection. They also started reassessing people's care plans and risk assessments.

Supporting people to eat and drink enough to maintain a balanced diet
● People were positive about the food and drink they had, particularly since the new cook had started. One person told us, ''The cook is brilliant. I always clear my plate and we can always have something else if we want it.''
● There was plentiful food and drink available for people throughout the day and people were offered food and drink regularly.
● The cook and staff team knew how to support people who had specific dietary requirements or needed their food prepared for them in a certain way.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● People were supported in line with the MCA and capacity assessments were made with people who may lack the capacity to make decisions. Decisions were made in people's best interests.
● People told us staff asked for consent. One person said, ''[Staff] always ask me before they help me with anything, although they know how I like things to be done.''

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

● People were not always treated with dignity and respect. Staff went into people's bedrooms without knocking and asking if they could enter. One person said, ''[Staff] will just come into my room and tell me it is time for tea or lunch. Sometimes it wakes me up.''

● Some people needed support to eat and staff members would stand above them when supporting them. This is not dignified. We heard one person say, 'I do not want my lunch' and the staff member responded by saying 'fine' in a frustrated tone. This did not show dignity and respect.

● People's home environment was not being kept clean and some equipment and furniture needed replacing. Moving and handling equipment was placed around communal areas meaning they did not feel homely. One relative said, ''It really feels like [family member] is in a care service rather than a home. It is a shame.''

● Staff did not know people well as individuals making it difficult to respect their equality and diversity. One relative told us, ''I do have some concerns [staff] do not know what to talk to [family member] about. Particularly if they have only worked with [family member] a few times.''

● There was a lack of focus on supporting people to remain independent if this was their choice. Care plans did not detail how staff may be able to support with this. One person said, ''I would like to do more myself, but it takes me a long time so [staff] end up doing it for me.''

● Despite our findings, staff did speak with people with kindness and compassion for the most part. People's comments included, ''[Staff] here are lovely- always ready to help with a big smile.'' and, ''[Staff] look out for me and make sure I am alright.'' One relative told us, ''The care is fantastic at the Victoriana. There is nothing [staff] would not do for [family member].''

● Some staff supported people to remain independent in areas such as eating and drinking. Some people left the service independently and this was encouraged by the staff team.

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

● Staff offered people choices in their day to day lives. For example, what people would like to eat and drink or whether they wanted to come to communal areas or stay in their rooms. However, there was no evidence that people or their relatives had been involved in making decisions about people's wider care and support.

● People and relatives told us they were not involved in informing care plans. One person said, ''I have never been shown any paperwork and never been asked what I think.'' A relative told us, ''I have not been asked about [family member's] care and support. I did not realise I was able to be.''

● The management team told us they would contact people and their relatives to involve them in wider

discussions about people's care and support.

Inadequate

Is the service responsive?

Our findings

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

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

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

● People did not receive personalised care. Staff did not know people well as individuals and there was a lack of focus on people's interests or specific support needs.

● In our discussions with people, we found out information about their past experiences, their interests, likes and dislikes. These had not been recorded in people's support plans and staff were not aware of these. In most cases people's support plans stated they had 'no interests. One person said, ''Staff are OK, but it is just a quick hello. They do not really know what I like.''

● People were living with specific health conditions, however staff had not been given training how to support them with these. There was limited or no information about these health conditions in people's support plans. One relative told us, ''[Family member] is living with [health condition] but I do not think staff know much about this or how it impacts them. For example, I know [family member's] room could be brighter to help them, but this has not been organised.''

● Staff told us it took a long time for changes to be made to people's care if their needs changed. For example, some people needed different equipment to support them to move around the service. If their needs changed in this area, reassessments were not organised in a timely manner.

● People had a lack of choice and control about their care and support. Some people did not receive personal care when they wanted it. One person told us, ''Depending on the day I have to wait quite a while before I am seen to. I like to get up [at time of day] but this does not happen.'' Records did not make it clear when people were supported with personal care or whether this was happening on a regular basis.

● People and relatives shared their concerns about person centred care with us. One person said, ''I used to do so much at home but there is nothing to do here. The staff just do it.'' A relative told us, ''[Personal belonging] means a lot to [family member] but the staff did not make it visible to them in their bedroom despite me asking them to do so. This made [family member] very upset.''

● People were not supported to follow their interests and there was a lack of social engagement at the service. People's individual likes and dislikes relating to social engagement had not been considered or catered for. Staff completed some group activities such as bingo or board games with people. However, people showed little interest in these and there was no evidence that these had been discussed with people to ensure they were interested in them.

● People spent a lot of time without any social engagement from staff either in their bedrooms or in communal areas. Staff spoke with people politely, however these interactions were task based and did not involve meaningful discussion with people. One person said, ''There is not a lot to do here.'' Another person said, ''I just sit around all day. It feels like I am in a prison.''

● Relatives explained their concerns around the lack of social engagement for their family members. Their

comments included, ''It would be nice to see [staff] do more. All they do is help [family member] to walk a few minutes a day and that is it.'' and, ''I have only ever seen [family member] in their bedroom. They do not seem to have anything social to do in the communal areas.''

We found no evidence people had been harmed. However, people were not receiving person-centred care tailored to their preferences, likes and dislikes and were not being supported to take part in social past times relevant to them. This put people at risk of harm. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team told us they would be focusing on getting to know people's preferences and adding these to their support plans. They also said audits would be completed to ensure people were engaged in social pastimes relevant to them.
● People were supported to see their friends and family at the service. One relative said, ''[Staff] have always been very accommodating regarding visits which has been much appreciated over the last couple of years.''
● Despite our findings we also received some positive comments from people. One person said, ''It is lovely here and I have no complaints. [Staff] know how I like things.''

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 (AIS). The AIS 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.
● There was limited evidence that the AIS had been considered in people's support. Documents such as care plans and policies were not available for people in accessible formats. There was no or limited information in people's support plans about how best to communicate with them.
● There had been some attempts to make food menus accessible by using photos. However, this had been an action for the service to complete for over a year and had yet to be fully implemented.
● Staff were not trained in different communication methods and spoke with everyone verbally. Staff told us they would 'speak louder' if someone did not understand them. One relative said, ''[Family member] cannot hear well which is a problem. However, I do not think anything is in place and we have been told to speak louder.''

We recommend the provider consider current guidance on the Accessible Information Standard and how this should be implemented to help improve the way in which people are spoken and communicated with.

● The management team told us they would be considering the AIS in future audits and reviews to help make sure it was embedded at the service.

End of life care and support
● Staff did not have formal training in supporting people at the end of their life. Plans in place for people at the end of their life lacked specific detail and were not person-centred.
● The management team responded immediately and organised training for the staff team. They also told us they would review end of life care plans during audits of support plans.
● Despite our findings staff spoke about how they would treat people at this time of their lives with dignity and respect. They also told us they could contact external professionals if this was necessary.

Improving care quality in response to complaints or concerns

● There was a complaints policy in place and people and relatives knew how to raise concerns. One relative said, ''No issues raising concerns and I feel comfortable doing this.''
● Complaints were responded to in a timely manner.

Inadequate

Is the service well-led?

Our findings

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

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

At our last inspection the leadership was not effective at times in promoting safety and monitoring the quality of care provided at the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

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; Continuous learning and improving care

- There had been a lack of manager presence and leadership at the service. This had led to a negative staff culture developing and numerous issues which required attention not being picked up in the provider's audits.
- We saw limited evidence of audits being completed to monitor the quality of the service. Audits did not pick up on issues we identified at this inspection including poor risk assessments, infection control concerns, poor recording of incidents and accidents, staff training, people being treated with dignity and respect, a lack of person centred care and social engagement and a lack of managerial oversight.
- There had been frequent changes at manager level and no oversight from the provider. This made it extremely difficult for these issues to be discovered or addressed.
- A lack of management oversight had led to issues such as those relating to people's support needs changing and not being reassessed. Staff competencies and observations were not being completed to help ensure people were always being treated with dignity and respect.
- There was a service improvement plan in place at the service. Some actions on this improvement plan such as sourcing staff training or making care plans more person centred were still outstanding from February 2021. The management team had also not acted swiftly when people's support needed reassessing in areas such as moving and handling. This showed a lack of addressing known issues.
- Staff did not feel supported by the management team and as a result a negative culture had developed at the service. Management had not picked up on or challenged staff practice which needed improvement. For example, staff basing people's support around the way they worked rather than what people wanted. This did not empower people to be a part of the service.
- The new management team had plans in place and were challenging staff practice. However, due to the embedded negative culture, staff felt unsupported. This had the potential to impact on the support people were receiving.

● People felt support at the service had not been as positive recently. People's comments included, ''There is no structure here. I am treated like a little boy rather than an adult. I just want it to be like it was before I came here'' and, ''I am not sure what has happened. Used to always be someone coming and asking how I was but not anymore.''
● Relatives also had concerns about the service. One relative said, ''[Service] is not somewhere I would want to be myself. We have nothing to compare it to.'' Another relative told us, ''The care has not been too good recently and we have thought of moving [family member]. However, hopefully the new management team will make a difference.''
● The nominated individual did not have a full understanding of the issues at the service. There had been a sustained lack of improvement at the leading to a negative culture and poor outcomes for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People, relatives and the staff team were not being engaged with to give feedback about the service. We could see no evidence of meetings or discussions taking place to collect feedback.
One relative said, ''There has definitely been a lack of communication recently. We used to get information regularly, but this has not happened for some time.''
● People and relatives were not supported to be a part of support and care plan reviews. One relative told us, ''We never get contacted to take part in any reviews. Only if something like a fall has happened.'' One person said, ''I am not even sure I have a care plan.''
● We were not shown any evidence that people, relative or staff views were sought in the form of surveys or questionnaires. There was no evidence that feedback was being actively sought and used to improve the service.
● Staff did not feel listened to and felt unable to feedback about the service. There was no evidence of regular staff meetings or discussions being held.

We found no evidence people had come to harm. However, leadership and governance was ineffective and had not picked up on areas where improvements were needed. A negative culture had developed at the service leading to negative outcomes for people. People were not asked to feed back or be involved in the development of the service. This put people at risk of harm. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team responded immediately to some of our concerns. They put audits in place to monitor the quality of the service, organised staff training and competency checks and increased monitoring of people's quality of life and social engagement. However, more time would be needed to fully embed these changes.
● The management team told us they would start seeking feedback from people, relatives and the staff team. This would be added to support plans.

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 provider had not informed us of statutory notifications which they are required to do so. For example, they had not let us know of serious injuries or possible allegations of abuse to people such as unexplained bruising or a fall which ended up in an injury for a person. The management team completed this retrospectively during our inspection.
● The lack of management presence at the service made it difficult to identify when things had gone wrong. However, the management team showed us evidence specific concerns people raised were looked in to and responded to appropriately.

Working in partnership with others

- The management and staff team worked with health professionals such as physiotherapists and GP's to help achieve good outcomes for people.
- The management team had plans in place to link with community partners such as churches to support people with social engagement.

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 9 HSCA RA Regulations 2014 Person-centred care We found no evidence people had been harmed. However, people were not receiving person-centred care tailored to their preferences, likes and dislikes and were not being supported to take part in social past times relevant to them. This put people at risk of harm.

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found no evidence people had been harmed. However, systems were not in place to assess risks effectively and put measures in place to keep people safe. The service was not clean and infection control measures were not being followed. This put people at risk of harm.

The enforcement action we took:

Warning notice.

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 We found no evidence people had been harmed. However, systems were either not in place or were not effective in safeguarding people from the risk of abuse. This put people at risk of harm.

The enforcement action we took:

Warning notice

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found no evidence people had come to harm. However, leadership and governance was ineffective and had not picked up on areas where improvements were needed. A negative culture had developed at the service leading to negative outcomes for people. This put people at risk of harm.

The enforcement action we took:

Warning notice.