Jeesal Residential Care Services Limited

Treehaven Rants

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Treehaven Rants is a residential care home providing support to autistic people and people with a mental health, and or learning disability. The main house is divided into two areas referred to as "Rants" and "Boomer". The service is registered for up to twelve people, however, because of the adaptations to create more space for people the service chooses to accommodate ten people and eight people lived there at the time of our inspection.

People's experience of using this service and what we found
Inspectors found the standards of care had significantly reduced since the last inspection.
The support and care people received was based on the availability of staff and routines were staff led and not around the needs and interests of people using the service. People did not have consistent care and regular routines which were identified as very important to them.

The attitudes and behaviours of staff did not ensure people received safe care. There was a culture of underreporting which meant people were not protected from possible abuse. People were exposed to unnecessary risk and were living in an environment which did not promote their wellbeing or keep them safe.

At the last inspection although rated good, concerns were raised about the condition of the environment and external grounds. Despite assurances being provided by the registered manager at the time that these issues were being addressed we found at this inspection widespread neglect of the care environment. The environment was no longer fit for purpose, neither was it hygienically clean. We found multiple issues with the environment which posed some immediate risks and had resulted in one person being temporarily removed from their flat without consultation with family or other health care agencies to ensure it was in their best interest. We sought immediate assurance and clarification of urgent works and went back on site a week later to check remedials works had been completed.

We asked for assurances from the registered manager of the cleanliness of the service as we found no evidence that staff were routinely cleaning the service or that enhanced cleaning schedules had been put in place since COVID-19. The building was visibly dirty throughout. A deep clean was authorised by the provider and took place. When we returned a week later, we noted some improvement but were concerned about the continued lack of regular cleaning of the premises.

During the restrictions imposed on the country as a result of COVID-19 we found that people had not been appropriately supported or adequately protected from contracting the virus.

A high number of incidents of behaviour had occurred which could be attributed to a change in people's routines and restrictions on their day to day lives. Incidents were not managed well or appropriately escalated. There was poor incident analysis, and adequate steps were not taken to reduce the likelihood

and, or severity of incidents reoccurring. Several incidents such as trips and falls could have been avoided if appropriate, timely actions had been taken by staff.

The service was poorly managed, and governance and oversight were weak. A new registered manager had come into post in August 2020. They had not been appropriately supported and had been unable to effect positive change within the service because they told us they were constantly, 'Firefighting.' A poor staff culture meant staff were not working together in a cohesive way to make lives for people living at the service better.

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

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

People did not have a voice and were not able to influence the service they received. Staff did not maximise people's independence or enable people to retain or develop new skills.

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

The last rating for this service was good (published 22/03/2019).

Why we inspected
The inspection was prompted in part due to concerns received about the service in relation to a number of safeguarding incidents and concerns about other locations under the same care provider.

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.

During the first day of our inspection we identified serious concerns. We sought immediate assurances from the provider about actions we wished them to take and asked the provider to confirm in writing the actions they had taken. We went back to the service to check they had made some immediate improvements requested. We found the provider had taken some initial remedial actions, but there continued to be significant risks and concerns present at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for

Treehaven Rants on our website at www.cqc.org.uk.

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care which included: infection control, safe care and treatment and the management of medicines. Safeguarding people from harm and risk. staffing levels, staff training and competencies. We also found breaches in relation to consent, dignity and respect as well as with the condition of the care environment. Management and governance, and registration requirements both notifications and adhering to conditions of registration were also areas where we found breaches.

Since the last inspection we recognised that the provider had failed to act within its own registration conditions. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

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

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

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

The Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

The Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well led

The Details are in our well led findings below.

Treehaven Rants

Detailed findings

Background to this inspection

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

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 undertaken over two days by two inspectors on 6 and 13 July 2021.

Service and service type
Treehaven Rants is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced on both days.

What we did before the inspection
The provider was asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We take this information into account when we inspected the service and made the judgements in this report.

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 all this information to plan our inspection.

During the inspection
On the first day of inspection we requested information and access to their electronic care management system. We carried out observations across the day and spoke to people on site. We interviewed four care staff, spoke with the deputy manager and senior team leader. We also spoke with the nominated individual We carried out a review of medication and the arrangements for infection control.

The day after our site visit, we requested additional information and asked for some immediate actions and reassurances from our finding on the previous day. We re-inspected the service the following week when we spoke with an additional member of care staff, carried out further observations and discussion with people using the service. We also interviewed the manager who had not been on site the previous week.

After the inspection
We continued to seek clarification from the provider to validate evidence found and to ensure ongoing improvement. We looked at training data and quality assurance records which included the environmental action plan and more generalised action plan. We spoke with the local authority and made them aware of our concerns and findings. We spoke with a health care professional. We spoke with two relatives by telephone.

We gave both verbal and written feedback to the registered manager on 19 July 2021.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse.
●This inspection was prompted by a high number of safeguarding concerns received by the local authority. The provider did not have adequate systems and processes in place to monitor accidents and incidents. Accidents and incidents had not been adequately reviewed, reported to CQC and not all had been notified to the local authority safeguarding team
●There was a poor staff culture and staff were either unable or unwilling to escalate concerns around the poor practice of colleagues. One family member told us the oversharing of information could make their family member anxious. We observed staff discussing information which was not appropriate in front of people with no regard to its possible impact.
●Staff said their training was inadequate and they felt unable to meet people's needs and reduce distress behaviours. A family member told us staff understanding of autism was poor and they worried about the consistency of care provided. Staff reported feeling unsafe.

People were not protected from the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse or improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management: Lessons learnt
● People were exposed to risk. One person had numerous falls and factors contributing to this had not been fully considered or reduced.
●Behaviour support plans had not been reviewed and updated after significant incidents and some documentation showed no review for more than two years.
●Unidentified risks led to accidents and incidents which could have otherwise been avoided. This included assaults on staff and people using the service. The risk assessment process was not robust.
● Risks associated with social activities, travelling and the environment had not been fully considered exposing people to avoidable harm. The design of the building had not been taken into account when considering incidents which could occur. For example, staff were not provided with any means to contact other staff in an emergency. The corridors were narrow and there had been a number of incidents occurring in the kitchen which is an area of increased risk.
● Broken and poorly maintained equipment and premises had resulted in one bedroom considered unsafe and the person temporarily moved out. Other areas of the service and external grounds were also in a poor state of repair. and although remedial actions had been identified months earlier little had been rectified
●One person was at high risk of choking and had recently choked. Prior to them choking they required a finely chopped diet with added moisture. Following the episode of choking this was changed to a pureed diet and thickened fluids which regular staff were aware of. However not all staff had up to date training in

the risks of dysphasia and had not all completed first aid training. There was no separate nutritional care plan in place for him. Although their needs were reassessed following an incident of choking this did not take place until 28 days after the incident. Their records were not updated to take into account changes in their needs and the incident was not referred to the local authority safeguarding team or CQC.

People were not protected from avoidable incidents and accidents which could result in avoidable harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our first inspection visit we requested that the provider take some immediate remedial actions to safeguard people and ensure records were up to date.

Using medicines safely

● People did not always receive their medicines as intended. Required when necessary medicines [PRN] had been administered inappropriately without a clear rationale or without seeking management approvals before administering it.

●The medicines policy had not been updated and did not reflect current guidance particularly in relation to: Stopping the over medication of people with a learning disability, autism or both (STOMP). Staff were not aware of this guidance and had not received adequate training in managing people's behaviour without the use of medicines.

● The service did not always have enough staff to ensure two staff administered medicines in line with the medicines policy. There was no contingency plan to mitigate risks associated with lone medication administration.

● Medicines were not always managed safely. Staff did not consistently record the temperature medicines were stored in. This had been identified as part of the monthly management audit but remained outstanding during our inspection.

● Medication errors were noted, and staff had recorded that they had sought medical advice. We could not see any recorded action to demonstrate how staff had been supported to ensure their competencies.

Staff were not appropriately trained and supported to give medicines as appropriate and as prescribed. This is further evidence of a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Hygiene practices were poor and did not promote people's safety. Regular cleaning was not carried out throughout the day.

●Staff consistently told us they did not have time to clean as they were there to support people. People were reluctant to keep their rooms clean and records were not kept showing how frequently shared facilities like bathrooms were cleaned. The home was dirty and poorly maintained. Some immediate assurances were sought and actions were taken to immediately improve the environment and cleanliness.

● The provider's infection prevention and control policy was up to date, but staff were not consistently following the policy and the management oversight of cleanliness was poor.

● We were not assured that any infection outbreaks could be effectively prevented or managed. Contingency plans were poor, and the risks of community transmission had not been considered.

● We were not assured that the provider was meeting shielding and social distancing rules. The environment did not easily lend itself to zoning and social distancing.

● We were not assured that staff were wearing their personal protective equipment (PPE) effectively. There were minimal spot checks on staff and previous concerns had been raised about staff not wearing PPE.

● We were not assured that the provider was admitting people safely to the service when people were going between different health care settings.
●We were not assured that people more predisposed to the risks of COVID-19 were adequately protected.
● We were assured that the provider was preventing visitors from catching and spreading infections because visitors were not coming on site.
● We were assured that the provider was accessing testing for people using the service and staff.
We have also signposted the provider to resources to develop their approach.

There was a lack of adherence to guidance about infection prevention and control and inadequate systems and processes in place to ensure enhanced cleaning was taking place to reduce the risk of cross infection. People and others were not protected fully from the risks of COVID-19. This is further evidence of a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our first inspection visit we required the provider to take some immediate remedial actions to make the environment cleaner and safer. The provider had taken some actions by our second day of inspection.

Lessons learnt
●Repeated incidents and avoidable accidents demonstrated that lessons learnt was not effective in identifying and improving the effectiveness and safety of the service.
●Not all incidents were effectively reported, escalated and analysed to help ensure the likelihood of further incidents were reduced.
●Not all incidents had been uploaded to the system. This meant the manager did not have all the relevant information to establish patterns or trends.

Staffing levels: Staff Recruitment
● Staffing levels had been recently compromised by the decision taken by the provider to temporarily remove a person from the location and support them remotely. This took additional staffing to manage their needs safely. We were not assured people always received safe care or their allocated hours so they could participate in their planned activities. It also meant the service was not regularly cleaned, management hours were compromised and there was inadequate focus on maintenance.
● Staffing levels had not been considered in line with the number of incidents. The turnover of staff and continuity for people had been affected recently in which almost all staff and people using the service had tested positive for COVID-19.This had resulted in higher sickness levels and staff reported during our inspection that they were tired and some had been working long shifts which meant they were not as effective.

The provider had failed to ensure there were enough numbers of suitably qualified, competent, skilled and experienced staff on each shift. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We reviewed the recruitment records of the last two members of staff employed and found recruitment records were adequate. They demonstrated the necessary checks had been carried out to ensure new staff had the necessary skills for their role and did not have a positive disclosure and barring check which might make them unsuitable for their role.

Inadequate

Is the service effective?

Our findings

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

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
● Staffs' knowledge and experience varied, with high numbers of agency staff working alongside permanent staff. Staff were not all familiar with people's needs.
●Communication was fragmented across the shift with frequent changes of staff supporting people across the day. Handovers were verbal and relied on staff telling other staff about any changes. The service relied on electronic messaging and reported poor Wi-Fi signalling which meant information might not always be accessible.
● We found guidance for staff was not adhered to which would have ensured safer practice. For example, the infection control policy and the medicines policy. Staff did not have good infection control awareness or complete regular cleaning to reduce the risks of cross infection. The medication policy had not been updated since 2018 and the policy recommended as good practice that two staff administer and witness medication. This was not always the case. On the second day of our inspection only one staff was administering medication. Guidance around falls had not been followed. One person had fallen regularly and hit their head and medical advice was not always requested.

Supporting people to live healthier lives, access healthcare services and support
●Poor information sharing resulted in delays in people accessing necessary health care. One family member raised concerns that their relative was waiting to be seen for a serious health condition and this had been delayed. We were unable to find evidence in the persons health care section that staff were following this up. Another person's records stated that they were going to have a head scan recommended in May 2021. The notes were inconclusive, so we asked the registered manager for the results. These were not provided. Following the inspection, we spoke with a health care professional, who told us the scan had not taken place and had not been followed up. They told us from the notes of the medical records that there were a number of entries where they had been unable to get through to the service to speak to staff to arrange appointments. They said at times the phones had been turned off. The registered manager had been off for a number of weeks and she normally dealt with appointments
● Staff told us people had not been seen regularly by the chiropodist and people were expected to cut their own nails, but some people found this difficult. There was no evidence in health care notes that people had access to regular chiropody or that staff had followed this up.
● People visited the dentist, but oral health assessments had not been completed to establish the condition of people's gums and mouth care needs.
● Health records were not in place for the people we case tracked so we were unable to see when people last check-ups or appointments had despite being told by staff about some recent changes in people's

needs.
Supporting people to eat and drink enough to maintain a balanced diet
● Regular staff were aware of risks to people when eating, but information was poorly documented. A report by the speech and language therapist was in place for one person we case tracked but there were no specific nutritional care plans or risk assessment linked to specialist diets or risks associated with swallowing or drinking .
● Several people were predisposed to health conditions due to advancing age and, or obesity. There was no plan of care to help ensure people were supported to access a healthier lifestyle which could reduce the risk
●People were supported to go shopping and staff said people could go into the kitchen and assist with meal preparation. We asked one person if they cooked and they told us only on a Sunday and said other times staff prepared their meals where with support they could do this for themselves. We saw little staff engagement with people to help them select and prepare what they would like to eat.

Staff support: induction, training, skills and experience
●Staffs' training was not up to date to ensure they had the knowledge and skills to support peoples' needs. For example, not all staff had completed training in Non-Abusive Psychological and Physical Intervention (NAPPI.) This was despite an escalation of incidents in the service and staff reporting feeling scared. Staff had not received adequate training in breakaway, de-escalation or physical intervention. This put them and people using the service at significant risk
●Nine staff did not have an up to date first aid certificate which now included training on swallowing, choking and dysphasia. There were a number of people in the service at risk of aspiration and insufficient numbers of trained staff to support them.
● Staff completed basic training in subjects like autism awareness but this was not in line with people's complex needs and a family member told us staff were not adequately trained and did not understand triggers for behaviour. Staff new to care were expected to complete the Care Certificate which covered the skills and competencies for staff working in the care sector. Care certificates had not been signed off or staff assessed as competent to carry out care effectively.
● Supervision of staff took place, but the registered manager confirmed staff did not receive regular support to reflect and improve their practice. Annual appraisals did not take place and no competency checks had been completed. Support workers did not have specific roles they were responsible for which meant the senior team leaders carried a lot of the responsibilities whilst also trying to deliver hands on care. This resulted in things not getting done.

The provider had failed to ensure there were enough numbers of suitably qualified, competent, and skilled staff. This was a breach of Regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
●At the last inspection in 2019 concerns were identified about the environment as adequate maintenance arrangements were not in place. During this inspection we found widespread concerns with the environment people were living in and sought immediate assurances and required actions from the provider to make the area safe.
● Uneven paving stones were a trip hazard and the grounds were poorly maintained. The registered manager said barbeques were taking place but the outdoor spaces we observed were overgrown and full of pot- holes after the rain. We could not be assured that people were safely able to access outdoor areas of the service.
● Internally we found broken window restrictors, fire doors propped open and damage to people's property. An action plan was in place, but deficits had not been addressed in a timely way. Some of these issues had

been identified eight months earlier with no action taken.
● People were at risk from harm as the environment was unsafe and unsuitable. It had narrow corridors and confined spaces so if a person was distressed and displaying certain behaviours the likelihood of injury to themselves, staff and others was greater. One person had a physical disability and internal steps were observed to impact on their levels of safety and independence.

The provider had failed to ensure people lived in a safe, and well-maintained environment. This was a breach of Regulation 15: Premises and equipment 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 decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● People had DoLS in place, and restrictions on their movements, but not all of these were in date and not all had been authorised. Staff were unaware who had a DoLS and the implications of the associated conditions in place. This placed infringements on people's human rights.
● The provider and registered manager were not acting lawfully in terms of best interest decisions and we found evidence of one person being removed from the service when it was unlawful to do so. No best interest meeting had taken place and the local authority and family had not been advised.
● We found staff were making decisions in the usage of PRN and not as directed resulting in restrictive practices.
●Specific mental capacity assessments had not been completed and best interest decisions were not recorded to demonstrate involvement of relevant people.

People were not supported in line with the principles of the Mental Capacity Act 2015. This was a breach of Regulation 11. Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity.

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

● Goals and aspirations for people were poorly recorded. Initial observations were that people related well to staff and asked staff for support. We found however that staff were inclined to do things for people which given time and support they could do for themselves. One person was watching their washing go around and when it was finished staff immediately put it in the tumble dryer without involving the person. A person confirmed staff prepared meals for them and we observed very little encouragement for people to do things for themselves.

● Activities were taking place but there was no consideration if these activities were in line with people's preferences and needs. For example, staff took people out for a drive. The purpose of these drives was sometimes to take staff somewhere, drop them off or pick them up from training.

●People's one to one hours were not always provided and there was no analysis as to whether people enjoyed doing activities with other people. Some activities had resulted in incidents in which people had been assaulted. This had not been reviewed or considered why people had become anxious.

● During our inspection we quickly identified there was an undercurrent with some staff underperforming and staff not all working together as a cohesive team. This would have an impact on people using the service who were likely to feel unsettled with any atmosphere in the home. Staff's unprofessionalism and blurred professional and personal boundaries indicated that there was a closed culture within the service resulting in people's needs not being prioritised.

●The environment did not uphold people's dignity. For example, windows did not have curtains. Shared bathrooms had resulted in one person urinating in their sink. There was nothing in place to ensure this person had access to the toilet when needed and to ensure their room was hygienically cleaned.

People's needs were not upheld in regard to their dignity and independence. This is a breach of regulation 10 : Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We saw limited evidence of how people were able to influence the service delivery or make decisions. Communication plans were poorly developed, and some people had limited circles of support who could advocate for them.

● People's care and support plans did not contain evidence of their involvement. We found no evidence of people agreeing to information being shared with other people. For example, we were aware of people's needs being reviewed by a range of professionals without the consultation of people using the service.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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 safe, well planned care by staff who were familiar with their needs. Frequent changes of staff and poor forward planning and communication put people at risk. Care and support plans were not up to date and did not take into account changing needs.
- Electronic care records did not include evidence of reviews and progress towards goals and there was limited information regarding people's cultural and religious needs. One person's record said they liked to go to church but there was no evidence of this happening or alternative arrangements being put in place during COVID-19 restrictions.
- The registered manager told us they had developed an activity schedule from March 2021 but stated this was not adhered to due to staffing. Staff referred to people going out when they could take them and not according to their needs or wishes.
- Records of behaviours were not kept consistently and staff were not proactive in raising concerns about people's welfare when this was compromised.

The care and support provided to people was not person centred and not in line with their individual needs. Support plans and risk assessments were not reviewed and updated in line with any changes. This is 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.

- The registered manager told us no complaints had been raised about the standards of care. People would require support to raise concerns and processes to facilitate this were not in place. From our findings of the culture within the service, we were concerned that people were not being encouraged to express their views or make complaints.

End of life care and support

- At the time of our inspection no one using the service was receiving end of life support. We found however, people had experienced significant loss and change. This had not been planned for and people were not supported to think ahead or process some of the experiences they might have faced. For example, one person talked freely of the loss of their pet, another person had experienced the loss of their parent. There was nothing in place to try and support them through this experience and help them understand the grieving process and to name and explore their feelings.
- One person had experienced significant changes in their needs, and it was felt the service might not be the right environment for them. This had not been explored thoroughly with other health and social care

agencies. There was no thinking ahead documentation in place and staff had not considered with the person if they did become ill what their wishes might be.

● There was a low staff uptake on training relating to relevant topics such as getting older and end of life care.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Staff told us that as they got to know people, they usually understood what they wanted. We found however people were not always supported by staff familiar with their needs. People's distress behaviours were poorly documented and poorly understood by staff including agency staff.

● Information was not accessible and did not help people make decisions. Decisions were often staff led and staff told us they did not use communications tools to help people make choices. The only visual information we saw was a staff picture board. This showed who was supporting who, but staff referred to frequent changes in staff and photographs of agency staff were not included

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership.

Leaders and the culture they created did not assure the delivery of high-quality care: Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Working in partnership with others: Engaging and involving people using the service.

- At the last inspection this service was rated as good. During the most recent inspection we identified a continued decline in the environment people were living in, a poor response to the COVID-19 outbreak and infection control processes.
- Robust systems and processes to assess, monitor and improve the service were not in place. We found limited evidence of audits being completed either in house or at provider level. We were not assured that records were kept up to date or factually correct.
- Audits, if completed, would support the management team to understand and identify any risks that required mitigation. However, we identified that actions identified by the registered manager some ten months earlier had not been addressed in a timely way resulting in a fall in living standards for people using the service.
- The provider had not invested in staff. Training was not up to date and staff were not supported to develop their professional practice or embed their practice in the workplace.
- The registered manager was poorly supported and was not assisted to help prioritise, particularly at times when the service was short of staff due to the pandemic.
- High levels of incidents and accidents put staff and people using the service at risk and adequate safeguards were not in place. Post incident reviews did not result in clear actions to mitigate risk. For example, staff risk assessments were not put in place for staff lone working or where staff had been subject to multiple assaults.
- The organisation had a health and safety team but very few incidents had been reported to them. We saw no genuine attempt to reduce the number of incidents.
- We found poor shift planning, poor communication on shift and poor documentation.
- Systems and processes were not in place to monitor, assess and evaluate people's risk assessments and care plans. This meant people were at risk of receiving unsafe care and care was not adequately planned around people's assessed needs.
- Systems and processes to monitor people's ongoing health, physical and behavioural needs were not in place. People were not accessing the services they needed to ensure their ongoing health and wellbeing and staff were not seeking guidance when struggling to support people.

Working in partnership with others: Engaging and involving people using the service

● We found limited evidence of people being involved in their care planning. People were not involved in the review of their needs. Some people had additional communication needs but this had not been adequately considered to ensure people had a voice. Information was not clearly accessible. People's consent was not always sought, and it was not always clear how decisions were made in people's best interest.

● Staff did not always feel empowered and were not supported to raise concerns. The closed culture at the service impacted on people living there.

●The registered manager was not effectively supported through induction, support and training. They did not have an established peer group where they could seek support and advice from. They were at times working excessive hours supporting care staff and did not always have protected management time to progress some of the tasks they needed to.

● Despite significant changes to people's needs the service had not been proactive in capturing people's views and the views of family, professionals and stakeholders. There was no evidence that feedback from people and staff helped to shape and improve the service.

This evidence meant the provider had failed to implement a robust system of quality assurance or to identify and address the shortfalls in the service. This was a breach of Regulation 17 (good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Some incidents had not been signed off by management, others had not been referred to the local authority safeguarding team which meant there was no proper oversight of incidents. Low notifications to CQC had meant increasing risks at the service had not been identified sooner so support could be put in place. During our inspection we identified that the service was not routinely reporting: any abuse or allegation of abuse in relation to a service user. It was also not reporting anything which could affect the service provider's ability to continue to carry on the regulated activity safely, such as staff shortages, and physical damage to the property.

Notifications not being reported to CQC is evidence of a breach of Regulation 18: (Notifications of other incidents). Care Quality Commission (Registration) Regulations 2009: Regulation 18.

Prior to our inspection the registered manager had been away from work for a number of weeks and we had not been notified once this exceeded more than twenty-eight days. This meant we were unaware and had not been told what the ongoing management arrangements and oversight arrangements were in her absence. This is a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 14

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 found no evidence that the provider understood their regulatory and legal responsibilities. They had taken decisions without due consideration to policy and whether their actions were in the best interest of the person.

●The provider had not ensured that safeguarding concerns and incidents were reported without delay or that families were always informed. They had not been open and honest. During our conversations we were given different accounts and were not able to always establish clear facts.

Continuous learning and improving care

● Action plans were in place prior to this inspection. They were not robust and did not set out how improvements were going to be achieved and embedded in the service. Subsequent action plans have been weak and without the necessary resources, making them unachievable.

● The service had not considered the longer term needs of people or ensured that both the environment and skill set of staff remained appropriate for the people they were supporting.
●Joint working with other health and social care professionals was minimal and gaps in people's health and support needs were identified by inspectors.
●The provider had a number of services where breaches of regulation have been identified and had not made the necessary improvements or learnt from one service to another.

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 9 HSCA RA Regulations 2014 Person-centred care The care and support we provider to people was not person centred and not in line with their individual needs. Support plans and risk assessments were not reviewed and updated in line with any changes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People did not receive care and support which upheld their dignity or facilitated their independence,

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not asked for their consent prior to care delivery and there was poor evidence of how the service always acted in people's best interest and followed the relevant guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not kept safe. Staff did not raise safeguarding concerns and measures were not in place to learn from incidents occurring between service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always adequate staffing to ensure people received safe and effective care around their needs.

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 14 Registration Regulations 2009 Notifications – notices of absence The provider had failed to notify us of the absence of a registered manager

The enforcement action we took:

Fixed penalty notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify us of reportable incidents.

The enforcement action we took:

Fixed penalty notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Section 33 HSCA Failure to comply with a condition The provider failed to operate within the terms of their registration.

The enforcement action we took:

Fixed penalty notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care and treatment and risks associated with the environment, infection control, safe administration of medicines and incidents and accidents had not been considered and planned for.

The enforcement action we took:

Urgent conditions imposed on the provider's registration at this location.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The environment was not safe for people using it. There was no effective programme of monitoring to ensure the premises and equipment was properly maintained. This exposed people to potential avoidable harm.

The enforcement action we took:

Urgent conditions imposed on the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was ineffective governance and oversight which put people at risk of poor care and harm.

The enforcement action we took:

Urgent conditions imposed on the provider's registration at this location.