Valorum Care Limited

White Windows

Inspection report

Fore Lane
Sowerby Bridge
HX6 1BH

Tel: 01422831981

Date of inspection visit:
08 June 2023
19 June 2023
07 July 2023

Date of publication:
22 August 2023

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

Summary of findings

Overall summary

About the service
White Windows is a residential care home providing personal care to 25 people at the time of the inspection. The service can support up to 25 people. White Windows supports people with physical and learning disabilities in one adapted building. White Windows is also registered to provide personal care to people in their own houses and flats but were not providing this service at the time of the inspection.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

The service could not show how they met some principles of right support, right care, right culture.

Right support
Risk assessments were not always followed to make sure people were safe. Medicines were not always managed safely and people's abilities in managing their own medicines had not been routinely assessed. Environmental risks were not always identified and addressed through audit systems. Staff were recruited safely but there were not always enough staff to meet people's needs and maintain a clean and safe environment for people. People were supported in the least restrictive way possible but where people had Deprivation of Liberty Safeguards (DoLS) in place, there was no evidence of conditions with the DoLS being met. We also found care records were unclear in relation to people's capacity and there were inconsistencies in the 'best interest decision' process.

Right Care
People were not fully supported to meet their social and recreational needs and there were times when their dignity needs were not fully met. People were not always protected from risk because some risk assessments were not being followed by staff. People told us they were happy with the staff who supported them. We observed some kind and caring interactions between staff and people. Staff knew people well but there were missed opportunities to fully involve people in their care and to promote people's independence. People's families felt involved in the care and support of their relatives.

Right Culture:
The provider's audit systems did not always identify and drive improvements in the quality of care and the safety of the environment. Although regular meetings were held, there were limited opportunities for people's views to be heard. At the time of the inspection, views of people's relatives about the service, were being sought but the outcome of this was not yet available.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 27 October 2022), and there were breaches of regulation. 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 carried out to follow up on action we told the provider to take at the last inspection.

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.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

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

Enforcement
We have identified breaches in relation to safe care and treatment, medicine management, staffing, need for consent and good governance at this inspection.

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

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

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

If the provider has not made enough improvement within this time frame 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? 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 always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

White Windows

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was carried out by 4 inspectors and 2 Experts by Experience. One Expert by Experience made telephone calls to people living at the service and their relatives and another visited the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
White Windows 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. White Windows is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The manager had submitted their registered manager application to CQC. We are currently assessing this application. We have referred to

them as 'the manager' in this inspection report.

Notice of inspection
This inspection was unannounced. Inspection activity started on 5June 2023 and ended on 19 July 2023. We visited the service on 8 and 19 June and 7 July 2023.

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 including Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 11 people using the service and 7 of their relatives about their experience of the care provided. We observed care in the communal areas to help us understand the experience of people. We spoke with 8 members of staff including the manager, deputy manager, care staff, the area manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included 6 people's care plans, risk assessments and associated information. We also reviewed multiple medication records. We looked at 3 staff files in relation to recruitment. A variety of records relating to the management of the service were also reviewed.

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.
Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although risk assessments had been developed, adequate systems were not in place to manage people's safety and therefore not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- The environment was not always safe for people.
- Bedrails were not always used safely or appropriately. For example, several beds had safety rails attached when the person didn't need them. There was a risk of staff, not familiar with the person, putting the safety rails in place.
- Risks to people had been assessed and risk assessments put in place. However, these had not always been followed. One person's risk assessment and care plan said they were at risk of choking, needed their food cutting up and a member of staff to stay with them whilst eating. We saw this person's food was not fully cut up and they ate alone in a room at both lunch and tea.
- People were at risk of choking as measures in place to reduce this risk were not followed. The speech and language team (SALT) had said one person was at high risk of choking and aspiration and needed an easy chew diet with textures that break up with a fork. The person's care plan said they were to be supervised when eating but not assisted. We observed this person eating lunch and tea. On both occasions they were not supervised and there was no evidence staff were monitoring in any way. The person was also served with meals that included food that did not meet their needs such as toast.
- Falls risks were not managed or monitored effectively. For example, one person's falls risk assessment stated the assessment should be reviewed monthly and after every fall. There had not been any review of the risk assessment for over 2 months.
- We were not assured risks nutritional and dehydration were being managed appropriately to keep people safe. One person's Weight, Nutrition& special dietary requirements care plan informed staff to keep records of their food and fluid intake. The deputy manager said they were not keeping records of food intake. The daily fluid intake target for the person was 1500 – 2000mls. However, fluid intake charts for a period of 6 days showed an intake for the whole period, of 2600mls. This meant the person was at risk of dehydration.
- Allergy information was not consistently recorded to protect people. One person had a hospital discharge letter on file that described a number of allergies the person had. Whilst some of the person's care documents referred to some of their allergies, there was nothing within their care plans to inform staff about how to support the person to protect themselves against their allergies.

This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were in place to make sure checks on environmental safety were made by appropriate professionals and contractors.

Using medicines safely

At our last inspection systems were either not in place or robust enough to demonstrate medicine were safely and effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (1) 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

● Medicines were not always stored safely. The medicines fridge, which contained insulin was unlocked on both days of the inspection with the key in the door. On the second day of the inspection the medicines room had been left unlocked with no staff in the vicinity. Medicines had been left on top of the trolley.
● The provider had not followed their own guidance for medicines storage. The service's own medicines audit said creams were to be stored in locked cupboards in people's bedrooms. We saw a large number of these cupboards were unlocked.
● Topical medicines were not always managed safely. One person had medicine patches applied each day. There was no recording of the application site for over 6 weeks. Record of application site is needed to prevent skin irritation.
● Body maps were not always in place for topical medicine application. For example, one person's cream was prescribed to be applied 'as directed' with no instruction to say where or how often.
● One person's care plan said they needed support from staff to apply cream to their legs. However, the manager told us this person was not prescribed any creams.
● Medicine records were not always accurate. One person's medicine, signed as administered, was still in the person's bedroom not taken.

This was a continued breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines stocks tallied with records of receipt and administration and controlled drugs were stored and managed safely.

Preventing and controlling infection
● We were not assured that the provider was promoting safety due to poor hygiene practices being followed at the service. For example, a catheter bag containing urine had been left in one person's bedroom and the bed rails in this room were heavily soiled. A heavily stained urine bottle had been left in a communal bathroom and communal baths and handwash basins were not clean. The flooring around the toilet in one bathroom was split.
● There were large cobwebs in several bedrooms and bathrooms and surfaces were unclean and dusty. Cleaning schedules on bathroom walls were out of date.
● Damage to items meant effective cleaning was not always possible. For example, there were holes in the covering of some bed rail covers and in the coating of one bed rail.
● Systems were not in place to ensure regular and robust cleaning across the service. One person's bespoke

chair had been left in a bathroom with another person's handling sling on top of it. The fabric cover of the chair was heavily stained with food. When we returned over a week later, the chair was in the same place and had not been cleaned.

We found no evidence people had been harmed. However, the provider had failed to assess and manage infection control risks. This placed people at risk of harm. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found examples of appropriate infection control practices in other areas. For example, the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People were able to receive visits from friends and family. Visits were only restricted, in line with current guidelines, during an outbreak of infection.

Staffing and recruitment
● Staffing levels were not always sufficient to meet people's needs.
● People and their relatives did not think there were always enough staff. One relative told us, "When the buzzers are going off it's annoying. The carers can't get there on time and residents can be left waiting for a long time." Another relative said, "At one time there were 5 male staff present in the evening, no females. They were from the agency."
● People who lived at the home said they sometimes had to wait for care. Two people told us there were not enough staff to respond to their call bells in a timely way. Both said they had been incontinent because of the wait.
● The provider had not always made arrangements to ensure enough staff were working at the service. On the first day of our inspection, 2 agency care staff had been booked. However, to make sure the staffing was at usual levels, including a 1:1 staff member, 3 agency staff were needed.
● There had not been no activities organiser working at the service for several months. No arrangement had been put in place to make sure staff were available to make sure people's needs in relation to social and occupational needs were met. People were very pleased the previous activities person was due to return. One person told us, "We are young people we want to get out." Another person said they would like to get out more but needed help because they were a wheelchair user.
● We were not assured there were enough staff to ensure cleanliness was maintained across the service. On the first day of our inspection the manager told us 2 cleaning staff were on duty. We found there was only 1 and they were working in the laundry. Rotas over a 3-week period showed several occasions when only one member of cleaning/laundry staff was on duty and on 2 days there had not been any cleaning/laundry staff at all.
● Employed staff were recruited safely but there were no risk assessments or agreements in place in relation to 2 volunteers from a local school who had been attending the service to spend time with people.

We found some evidence people had been harmed. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The manager made referrals to the local authority team as needed. However, they had had not always followed up on incidents. For example, one person had raised an issue of possible financial abuse. This had

been referred to safeguarding but the person was still experiencing the same issue.
● People living at the home told us they felt safe. One said, "Absolutely safe. I didn't like male carers, so they gave me two women carers." A relative told us, "(Person) has been there for fourteen years, and I know (person) is safe." Another relative told us they were aware of a safeguarding incident involving their family member but said their family member was safe whilst this was being managed.
● Staff knew what to do if they thought someone was at risk.

Learning lessons when things go wrong
● The manager was working with the local authority to develop their skills in analysing accidents and incidents looking for patterns and trends to try to reduce the incidence.

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.

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

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
- We were not assured that conditions related to DoLS authorisations were being met. The manager was aware conditions were in place on 2 people's DoLS. However, they were not aware of the detail of the conditions and there was nothing in place to demonstrate the conditions were being met. For example, one person's condition was for staff to discuss their activities care plan with them and to support them in taking part in activities of their choice. The manager said the person did not have activities care plan in place.
- The service was not always clear about gaining people's consent or following the that the best interest process appropriately.
- There was conflicting information in people's care files relating to capacity. For example, one person's consent and capacity form said the person had capacity to consent to a wide range of topics including having their medicines administered. However, a mental capacity assessment for this person just in relation to administering medicines, said the person lacked capacity in this area. Another person's form said the person had capacity, but the form was signed by a relative.
- Records lacked information about how people's consent was sought.
- There were inconsistencies in the best interest decision process. Best interest decisions were not always recorded or made in consultation with relevant parties.

This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's healthcare needs were not always managed safely.
● Advice from health professionals was not always being sought, recorded or acted on. We noticed one person had inflamed and bleeding legs. They told us they were sore. The person had been referred to healthcare professionals for this issue but there were no updates in the person's records since their last appointment several weeks prior to our inspection and a care plan to advise staff how to support the person with this issue had not been developed. We could not see any evidence of the person receiving their prescribed treatment.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We were not assured that people's needs were always assessed prior to admission. For example, for one person there was no evidence of any pre-admission assessment.
● People's needs in relation to following their hobbies, interests and preferred social activities had not been assessed and care plans had not been developed in relation to this. Following the inspection, the nominated individual told us 'interests checklists' were being implemented to capture people's preferences and choice.

Staff support: induction, training, skills and experience
● There was an induction process in place, but records had not been completed to show how new staff were supported in their first weeks of employment.
● Staff told us they received a lot of e-learning. One staff member said they didn't know who to go to if they hadn't understood something and would prefer face to face training so they could ask questions.
● The training matrix showed staff were generally up to date with their training.
● Staff had e-learning in relation to supporting people with a learning disability or autism.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always supported safely or effectively with nutrition and hydration needs.
● Staff did not always support people with their assessed needs in relation to eating and drinking.
● None of the people we spoke with said they were involved in planning menus. One person said, "I don't know who decides the menu: it's not me". Another person said, "The food is hit and miss, sometimes a bit bland".
● During a residents meeting, some people had raised concerns about the availability of food during the evening as they felt hungry with tea being at 4pm. Although there was little response to this during the meeting, following the inspection, the nominated individual assured us this was being addressed with the teatime meal moving to 5pm and food being made available for people in the evening.
● Weight records for one person showed a loss of 8kgs over the previous 2 months. Some records stated to weigh the person 2 weekly, but this had not been done. Whilst weight loss for this person may not have been a concern, there was no reference to weighing or weight loss in their care plans.

Adapting service, design, decoration to meet people's needs
● People were able to move freely within the service and access outside space as they wished.
● Issues with the call bell identified at the last inspection had not been addressed. The call bell sounded frequently and was very loud in all communal areas. We found our conversations with people were difficult when the call bell was sounding. One person said, "The buzzers are always going off, but you get used to it."

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 requires improvement. At this inspection the rating for this key question has remained 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's dignity was not always respected. Two people told us their dignity was not always maintained as they had been incontinent whilst having to wait for staff to answer their call bells.
- People's care records were not always written in respectful, person-centred language. One person's care record referred to them wearing a 'diaper'.
- Care records for people with a learning disability did not always the reflect the principles of right support, right care, right culture. For example, medicines care plans for 3 people all stated, '(person) has a learning disability so would not be able to manage (their) own medications'. There was no indication that people's abilities to promote their independence in this area had been assessed.
- Most people said staff were kind and caring, and felt they were treated with respect and dignity. One person said, "I am treated well; like a human being, the don't treat you disabled like in other places. They say it's my home not the staff's." Another person told us, "They are fantastic, and they help us quite a lot, but they are short staffed sometimes."
- Relatives told us, "(Person) likes it there. They look after (them) well – good set of staff", "Staff are always good and have time for everything. Whenever I see (person), they never have the same clothes on. They do (their) hair and make (them) look lovely. It gives (them) a boost" and "The staff are lovely and always treat (person) with respect. It makes me feel happy."

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

- There was little evidence of people being involved in or consulted about their care. A covering sheet was in place for people to sign to sign to say they agreed with their care plans but there was no evidence of the discussion that had taken place, particularly with people with a learning disability, to make sure they understood the content of their care plans.
- People's families felt involved in their relative's care. They told us, "Yes, I can make decisions about care because they always ask me if anything needs changing, I have seen the care plan and it is up to date. I feel involved because they ask me my opinions", "I do feel involved. They normally ring me up to arrange a meeting. The care plan is in place", and "We have always been involved in everything."

Requires Improvement

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 remained requires improvement. This meant people's needs were not always met.

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

- Although care plans were generally written with a person-centred approach, they lacked evidence of the involvement of the person and did not reflect people's goals, aspirations or future plans. Care plans for people with a learning disability did not always reflect the principles of right support, right care, right culture.
- There were missed opportunities to fully involve people in their care. For example, staff did not sit with and consult people when making records about their day. Doing this would have given people the opportunity so say how they felt about their care. One person told us, "I'd like to look at my care plan. Staff don't sit with me when they do the daily notes, it bothers me, I don't know what they write."
- People were not always included in the 'resident of the day' scheme. The document for staff to complete with the person included a review of the person's care plans and feedback from the person about how they were feeling and any feedback they might have about activities. The majority of 'resident of the day' documents did not include any evidence of the person having been involved in the process.
- Decisions about care record storage arrangements were made by the manager without consultation. On the third day of inspection the manager said people's care plans were going to be placed in a holder on the back of people's bedroom doors. No discussions had taken with place with people to establish if they were happy with this arrangement.
- People did not always have opportunities to be maximise their independence. A person whose care plan said they were receiving respite care until they could live independently, gave no evidence of the support the person was receiving or of any liaison with other professionals to help them to achieve this.
- The manager told us they were unsure of the future plans for a person receiving respite care but said their care plans reflected their situation. We did not find any evidence of this or of any actions taken by staff to establish the future care of this person.
- People were not always supported to go shopping or buy items of their choosing. One person told us they had been waiting several months for a bed of their choice. They said they were willing to pay for this themselves but was not getting anywhere in their discussions with the manager about this. Following the inspection, we received confirmation from the nominated individual that the person had been supported to go and choose a bed.
- The providers audit of April 2023 had identified that the activity provision for a person with a learning disability was not in line with the principles of right support, right care, right culture because the person was not accessing the community regularly. This person's finance records indicated there had not been any money spent by the person since February 2023 and care records for a period of 18 days showed the person had engaged in only one activity which was a game of bingo. The 'Plans for the future' care plan for this person said they were to be supported to visit local shops until they could do this independently. There was

no record of this activity having taken place.
● The activity records for another person with a learning disability showed the only activity they had engaged in for a period of 18 days was watching television.
● Our review of people's financial records evidenced staff making a number of purchases, for such as toiletries, on behalf of people, but records lacked evidence of people being supported to local shops to make their own choices. A member of staff said the reason for one person not going much was because they have a learning disability.
● People told us they were very pleased that the activities organiser had returned to the service. However, we found there was very little support from staff to enable the activities organiser to support people in person centred, age-appropriate activities. One person said, I like to go out but there's no staff to take me. Just going to the town would do."

The service was unable to demonstrate they were providing person centred care and supporting people to engage in activities socially and culturally relevant to them in line with the principles of right support, right care, right culture.

This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (regulated Activities 2014)

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (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.
●. We were not assured the provider was making information available to people in alternative formats. One person's records said the person needed their care plan to be provided to them in a particular font to support their reading of it. There was no evidence of this having happened.
Improving care quality in response to complaints or concerns
● People felt they could go to the manager or deputy and their concerns were listened to.
● Complaints were managed and responded to in line with the provider's complaints policy.

End of life care and support
● None of the people we spoke with had discussed their wishes about end of life.
● Some information in care files relating to 'Do not attempt resuscitation' orders was unclear and put people at risk of not receiving their chosen treatment. One person's documentation said, "I don't not have a DNCPR".
● Information in relation to 'Do not attempt resuscitation' orders was also not always made clear on people's hospital passports. It is important that this is clear in the event the person is admitted to hospital.

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 for this key question 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; 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

At our last inspection the provider had failed to ensure that systems for auditing the safety and quality of the service were sufficiently robust to identify risks to people's safety and welfare. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (regulated Activities 2014)

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

● Effective systems were not in place to monitor the quality and safety of the service. Learning had not always been taken from the results of audit and action had not routinely been taken to address issues identified. This resulted in us finding breaches of regulation relating to safe care and treatment, management of DoLS, person centred care and staffing. The provider had also failed to comply with the principles of right support, right care, right culture.
● The manager said they did not complete a daily walkaround to make sure the service was clean and safe. This meant they were not aware of the issues we identified in relation to hygiene and safety within the service.
● The provider had failed to identify the issues we found with medicines management, health and safety, risk management, staffing and person-centred care.
● Shortfalls identified at the last inspection had not been addressed. This was the second consecutive inspection where the service had been rated requires improvement or inadequate.

This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (regulated Activities 2014)

● The manager was in the process of their registered manager application to CQC.
● The manager had not undertaken any training in relation to managing a service.
● People felt comfortable in approaching the manager with any concerns and there was evidence they responded to people appropriately.
● The manager had not provided the nominated individual with a clear overview of the feedback we

provided to them on the first day of our inspection. The nominated individual told us they acknowledged the work that needed to be done at the service and assured us they would be taking an active role in driving improvement.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Engagement with people by the provider was minimal. People were not routinely given opportunities to be involved in planning and making decisions about their care and support arrangements.
- There were a number of opportunities missed for gaining the views of people who used the service and to involve them in driving improvement or in demonstrating a commitment to providing person centred care.
- Meetings for people who lived at the service were held and we observed one of these. People were asked to give their opinions and ask questions, but they did not lead the meeting. One person who was requesting a change to mealtimes was immediately told that meal arrangements had to be as the majority of people wanted them. The manager did step in and say they would look into how the person's request could be met.

Working in partnership with others

- The manager was working with the local authority to improve some of the systems within the service.

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 provider had failed to make sure people's care was planned and delivered with a person centred approach. The provider had failed to meet the principles of right support, right care, right culture.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to make sure that conditions on Deprivation of Liberty Safeguards were met. Care records were unclear about the process of gaining people's consent, how capacity had been assessed or that the best interest process was being followed appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to make sure the service was clean and that people's needs were met.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure people's health and safety. The provider had failed to promote people's safety safety through the hygiene practices of the premises. Medicines were not managed safely. Risks to people's health and safety were not managed appropriately.

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 The provider had failed to ensure that systems for auditing the safety and quality of the service were sufficiently robust to identify risks to people's safety and welfare.

The enforcement action we took:

Warning notice