Supported Living UK Limited

Foxhills Farm

Inspection report

Fontley Road
Titchfield
Fareham
Hampshire
PO15 6QY

Tel: 01329849008
Website: www.activecaregroup.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Foxhills Farm is a residential care home providing personal care to up to 5 people. The service provides support to people who live with learning disabilities and complex needs. At the start of our inspection there were 4 people using the service in 1 adapted building. During the inspection this reduced to 3 people using the service. The home has 2 floors accessed via stairs, communal areas and a large garden.

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.

Based on our review of key questions safe, effective and well-led, the provider was not able to demonstrate how they were meeting all of the underpinning principles of Right support, right care, right culture.

Right Support: 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.

Right Care: The service was close to a busy road, with no pavements, the nearest bus stop was over half a mile away along this road and there was no access to local shops, the closest place being a garden centre. However, since our last inspection the manager had worked on ensuring people were able to get out more often. People were at risk of harm because staff did not always have the information, they needed to support people safely.

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff did not fully ensure people using services lead confident, inclusive, and empowered lives.

At the last inspection assessing risk to the health, safety and wellbeing of people, medicines management and infection prevention and control were not managed safely, at this inspection this remained the same.

Recruitment was not managed safely, and people were at risk of being supported by staff who had not had the appropriate checks.

The service was not maximising people's choices, control, or independence. There was a lack of person-centred care.

The provider did not have enough oversight of the service to ensure that it was being managed safely and

that quality was maintained. Quality assurance processes had not identified all of the concerns in the service, and where they had, sufficient improvement had not taken place. Records were not always complete. People and stakeholders were not always given the opportunity to feedback about care or the wider service. This meant people did not always receive high-quality care.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 7 March 2023) and identified 9 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 7 regulations.

At our last inspection we recommended the provider sought current guidance on menu planning and updated their practice accordingly. At this inspection we found improvements had been made.
We also recommend the provider sought reputable guidance around the Data Protection Act and updated their practice accordingly. At this inspection improvements had been made.

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.

We carried out an unannounced focussed inspection of this service on 27 June and 4 July 2023. Seven breaches of legal requirements were found. We issued the provider with 4 warning notices in relation to Safe Care and Treatment, Need for Consent, Safeguarding Service Users from Abuse and Good Governance.

We undertook this focused inspection to check they had met the requirements of the warning notices and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained inadequate. This is based on the findings at this inspection.

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

Enforcement and Recommendations
We have identified breaches in relation to assessing risk, medicines management, safeguarding people, consent to care, staff recruitment, training, person centred care and governance and oversight at this inspection.

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

The overall rating for this service is 'Inadequate'. This is the second consecutive inspection with an 'Inadequate rating' and the service remains 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.

Following our inspection the provider notified us that they were closing and de-registering the service. The service was de-registered on 31 August 2023.

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Foxhills Farm

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 2 inspectors.

Service and service type
Foxhills Farm is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under 1 contractual agreement dependent on their registration with us. Foxhills Farm 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. However, a new manager had been recruited and had been in post for 4 weeks. They were planning to apply to become the registered manager.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 27 June and ended on 7 July 2023. We visited the service on 27 June and 4 July 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We carried out observations of people's experiences throughout the inspection. We received feedback from 3 relatives about their experience of the care provided. We looked at 6 staff files in relation to recruitment and staff supervision. We reviewed a range of records. This included 3 people's care records and 3 people's medication records. A variety of records relating to the management of the service, including policies and procedures were also reviewed. We spoke with 8 members of staff including the nominated individual, the operations director, the manager and 4 care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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 inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At the last inspection the provider failed to provide people with safe care and treatment and do all that was reasonably practical to mitigate risks. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and further concerns were identified. The provider remained in breach of Regulation 12.

- Risk assessments were not always in place to reduce the risk of harm to people. Care records identified 1 person had wrapped an electrical cable round their neck in March 2023. Although the specific item and cable had been removed to the office, there was no risk assessment in place around this identified risk and all potential ligatures had not been removed.
- Following the inspection the manager sent us a ligature risk assessment for this person, however, it did not contain any guidance for staff on what to do if the risk management plans in place failed. Although the staff had received ligature training and there was a ligature cutting device available, this was not detailed in the risk assessment. This meant agency and new staff may not be aware of the action to take in this situation.
- Support plans and risk assessments were not always clear. One person's care record stated they were at risk of high blood pressure. Their blood pressure was not taken consistently, and when it was taken, the readings were high. There was no guidance in place to alert staff when to seek medical support. Medical support was not accessed for the high blood pressure readings until this was pointed out on inspection.
- People were at risk of not being supported appropriately in the event of a fire. We spoke to 2 staff members who told us they had not had fire evacuation training for 4 or 5 years. The training matrix identified 1 staff member had not completed fire safety training and 2 staff's fire training were over a year out of date. This meant the provider had not ensured all staff were suitably trained and competent to support people in the event of a fire, placing them at risk of harm.
- Records showed safety monitoring checks in relation to fire safety were not carried out consistently in line with the providers policy. The provider had weekly and daily checks in place for fire safety, however, these had taken place only once in April 2023, not at all in May 2023 and 3 times in June 2023. The lint in the tumble dryer had not been emptied thus increasing the risk of fire.
- We saw a piece of furniture with a broken piece of sharp Perspex and screws sticking out, this had not been identified by the provider. This was in the sensory room, there was a risk of injury to people if they touched the broken Perspex.

The failure to ensure people were provided with safe care and treatment and risks were assessed, monitored

and mitigated were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed all of these concerns with the manager who took action to remove some of the risks.

Staffing and recruitment
At the last inspection we found the provider failed to establish and operate recruitment procedures effectively. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection enough improvement had not been made and the provider remained in breach of Regulation 19.

● Recruitment practices were not always robust; pre-employment records were not available in the service and staff were not recruited safely.
● Of the 6 recruitment files provided by the manager, 2 did not contain any employment history, 4 staff members employment history did not detail the date and month of employment only the year. It was difficult to establish if staff members had gaps in their employment history due to employment dates not being complete.

The failure to establish and operate recruitment procedures effectively was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staffing levels had improved since our last inspection, however, the manager told us they were funded for 3 early staff, 3 late staff and 2 night staff every day. We reviewed 4 weeks of rota. On ten occasions in the 4 weeks reviewed there were less than 3 staff on each shift and the rota we were provided with showed 2 nightshifts with only 1 staff member on duty. This meant there were not always enough staff to support people safely and effectively putting them at risk of harm.

The failure to ensure sufficient staff were on duty to support people was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment was ongoing. Since our last inspection the provider was providing transport to support agency staff to get to the service.

Preventing and controlling infection

At the last inspection the provider failed to assess the risk of and prevent and control the risk of the spread of infection which was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider remains in breach of Regulation 12.

● Infection prevention and control was not managed safely and was not in accordance with the provider's policy.
● The provider had 2 fridges and 1 freezer available to store food. Fridge and freezer temperatures were not taken consistently in line with the provider's policy. Fridge temperature recordings for the month of May

2023 were not available. When temperatures were taken, they were outside of the safe temperatures for both fridges for the month of June 2023. People's food had not been stored safely placing them at risk of consuming contaminated food.
● We observed 3 pedal bins which did not work and a laundry bin without a lid. This meant people and staff using the bins were at risk of contamination due to having to physically lift the bin lids.
● On the second day of inspection there were 2 refuse bins at the entrance to the drive, 1 had rubbish bags which were split and piled high to overflowing. Rubbish was all over the ground surrounding the bin and had spread all across the garden. This included some items of personal protective Equipment (PPE). There was a risk vermin would be attracted to the refuse and people could touch the used PPE which placed them at risk of infection and disease.
● Cleanliness had not been managed effectively at the service. We observed several cobwebs on windows, dirty windowsills, fans which were covered in dust and 1 person's bedroom was covered in crumbs and debris. In 2 people's bedrooms there was a malodour. A mat at the entrance to the kitchen was also visibly dirty and covered in debris. This meant people living in the service were at risk of infection from an unclean environment.
● We checked the cleaning schedules for the service, in a 9-day period, on 4 days there was no evidence any cleaning had taken place, there was no evidence of when bedrooms were last cleaned.

The failure to assess the risk of and prevent and control the risk of the spread of infection was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the second day of inspection the manager sent a staff member out to purchase a new fridge, a second-hand fridge was also in place and the temperature was in the safe range
● At our last inspection we reported the service did not have a refuse company to remove their refuse and was using a large skip in the garden. At this inspection the manager told us a refuse service had been secured and the skip was no longer in place.
● First aid boxes were in date and were being checked in line with the providers policy.
● We observed staff wearing appropriate PPE throughout the inspection.

Visiting in care homes
People and staff told us visitors were welcomed into the service. Relatives told us they could visit the service whenever they wanted to. Visiting was managed in line with current guidance.

Systems and processes to safeguard people from the risk of abuse

At the last inspection the provider failed to safeguard people from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider remained in breach of Regulation 13.

● Systems and processes in place to safeguard people from abuse were not always effective.
● Some restrictive practices in the service had not been assessed to determine whether they were necessary and proportionate in relation to the risk of harm, placing people at risk of excessive supervision and institutional abuse. For one person there was no clear rationale for the level of monitoring staff were undertaking and no documented evidence to show how it had been decided that this level of supervision was in the person's best interest to keep them safe when a monitor was also in place.
● Our evening observations showed a strict/ inflexible bedtime routine had developed and people did not have freedom and control over all aspects of their daily lives such as when they chose to go to bed.

● People's capacity had not been assessed and best interest decisions had not been made to support with identifying a suitable bedtime. People were not asked if they wanted to wash, get their pyjamas on, or go to bed at such an early hour. Staff told us, and documents confirmed that people got up throughout the night. Going to bed early adversely impacted on some people, who regularly got up through the night.

The failure to safeguard people from abuse and improper treatment was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider failed to operate proper and safe use of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection enough improvement had not been made, and the provider was still in breach of Regulation 12.

● Medicines were not always managed safely. People had 'as required' medicine protocols in place for all oral medicines. However, 3 people were prescribed paracetamol, '2 to be taken 4 times a day as required. All 3 PRN protocols guided staff to administer a maximum of 8g of paracetamol a day which is double the prescribed dose. This put people at risk of being administered an overdose.
● Medicines temperature recording was not done consistently for medicines kept in the medicine's cupboard and medicines fridge. There was a risk medicines could become ineffective if they were being stored at the wrong temperature.
● One person was prescribed Cetraben which is a skin barrier cream to be used as required. There was no Cetraben in stock. There was no PRN protocol for the use of this cream. Staff were recording this person had refused this cream despite it not being available to offer. We spoke to the manager about this who told us they would ensure this cream was available in future.
● Where people were prescribed flammable ointments, for example Cetraben, there was no risk assessment in place to ensure staff knew how to support people to reduce the risk of flammable cream building up on clothes and bedding. This put people at serious risk of harm.

The failure to manage people's medicines safely was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● At our last inspection we reported, 'When things went wrong, lessons were not always learnt to support improvement, and this was evident from our findings at this inspection. This meant the service did not demonstrate learning, reflective practice, and improvement.' At this inspection we found the same concerns. The provider failed to learn lessons from the last inspection and failed to put plans in place to make improvements to the service.

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 our last inspection we rated this key question inadequate. The rating for this key question has remained Inadequate. This meant there were widespread and significant shortfalls in people's care, support, and outcomes.

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

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

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

At the last inspection the provider failed to provide care and treatment with the consent of the person or in their best interests following mental capacity legislation. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection enough improvement had not been made and the provider remained in Breach of Regulation 11.

- The provider was not working in line with the principles of the MCA.
- Where people lacked capacity to consent, mental capacity assessments had not always been completed for specific decisions, and where capacity assessments had taken place there was not always a recorded best interest decision.
- Some family members managed people's finances. There was no evidence for 1 person, whose finances were managed by their family, that the family had Lasting Power of Attorney (LPA) or a court of protection appointed deputyship in place. If you are unable to manage your own affairs, an LPA is a legally appointed person of your choice, to do it for you. A court appointed deputy is assigned to manage people's property and affairs where they lack the capacity to do so themselves. The same concerns were found at the last inspection.
- Although the manager who had been in post since 1 June 2023 had a good understanding of the MCA,

they were not aware most of the MCA decisions did not have a best interest meeting documented. This meant they had not taken action to address this, and people were at risk of decisions being made not in their best interest.

Providing care and treatment without the consent of the person or in their best interests following mental capacity legislation was a continued breach of regulation 11 of the Health and Social Care Act 2008 (regulated Activities) regulations 2014.

Staff support: induction, training, skills and experience

At the last inspection the provider failed to ensure staff received appropriate training. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider remained in breach of Regulation 18.

● We were not assured staff always received the training they required to carry out their roles safely and effectively. A variety of training was available; however, staff were not always up to date with their training. Approximately half of the established staff team had not completed or were out of date for moving and handling, safeguarding, epilepsy, equality and diversity and nutrition and hydration training. This meant staff were not always sufficiently trained to meet the needs of the people they supported.
● Furthermore, out of the 8 established staff members, 3 were out of date for or had not completed fire safety, first aid, infection prevention and control, food hygiene and MCA and DoLS.
● At the last inspection only 1 staff member was trained in the provider's specified physical intervention training. Support plans and risk assessments mentioned specific physical interventions and accident and incident forms confirmed physical interventions were being used. However, staff who had not been trained were taking part in using physical interventions with people which put people at risk of serious harm. At this inspection this had improved, however, there were still 3 staff who had not completed this training and 3 staff who had not completed positive behaviour support training.
● In addition, new starters did not have any training recorded, this included 1 staff member who started in March 2023 and 2 staff members who started in May 2023. These staff members were observed to be working and were included in the staff numbers.
● Records demonstrated staff had not had access to regular supervision in line with the providers policy. We spoke with the manager about this, they told us staff had not had regular supervision and they had not yet completed any supervision with staff, however, they said they had booked in supervision for staff in July 2023.

The failure to ensure staff received appropriate training and supervision was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider failed to ensure people were provided with person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider remained in breach of Regulation 9.

● People's needs had been assessed when they moved into the service, however, support plans were not regularly reviewed and updated when people's needs changed. Systems did not evidence how people were supported to express and review how they wanted their care to be provided or how the home was run. People were not involved in developing their care plans. This meant staff did not always have the information required to enable them to provide people with good person-centred care.
● We also noted care plans did not include people's goals or longer-term aspirations to support their independence.
● Support plans did not cover the full range of people's needs. Care plans were written in a way that made it difficult to find information about people's preferences and wishes. There was not always a clear distinction of care need and risk, so staff could easily find the information they would need to meet people's individual wishes.
● At the last inspection we reported the television in the lounge was leaning forward pointing at an angle towards the ground. This made the television difficult to view comfortably. At this inspection the television was at the same angle, no action had been taken to rectify this to improve people's viewing experience.

The failure to ensure people were provided with appropriate person-centred care which met their needs and reflected their preferences was a repeat breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● After assessment people had been given access to their own food and snack cupboards which were no longer locked.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to dentists and opticians and a GP called the service once a week to discuss people's health needs. For one person there was a delay in seeking medical advice for a skin ailment.
● Since our last inspection the manager had worked on ensuring people were able to get out more often.

Supporting people to eat and drink enough to maintain a balanced diet
● At the last inspection we recommended the provider seeks current guidance on menu planning and updated their practice accordingly. At this inspection improvements had been made.
● People were offered a variety of foods. Evening meals were cooked by the staff and included 2 choices. We observed on inspection 3 people were all eating different meals in line with their choices and preferences.
● The vegetables on offer were not very varied with mixed vegetables being offered on 4 days of the week, however, this had improved since the last inspection where mixed vegetables were offered 7 days a week.
● Staff supported people appropriately during meals. We observed 2 staff members sat with people while they were eating and prompting people to slow down when necessary.

Adapting service, design, decoration to meet people's needs
● At the last inspection we recommended the provider sought reputable guidance around the Data Protection Act and updated their practice accordingly. At this inspection personal information relating to people was no longer displayed on walls.
● Following the last inspection some repairs had taken place, for example, the kitchen work surface had been repaired.
● There was a hole in the wall in the corridor, this had been filled when we returned for the second day of inspection.

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 inadequate. The rating for this key question has remained 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

At the last inspection the provider failed to operate effective systems to assess, monitor and improve the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At this inspection not enough improvement had not been made and the provider remained in breach of Regulation 17.

- The service continued to be not well managed. Risk and quality processes continued to not be operated effectively to ensure the service was safe and people were receiving high-quality care. This led to multiple repeat breaches of regulation and placed people at risk of harm as outlined in the safe and effective domains of this report.
- Although governance systems were in place, they were not effective, this was because they were not completed accurately or did not drive improvement. Some audits picked up on concerns we found during inspection, however, action had not been taken to address these concerns. Other audits failed to identify the areas of concern we found on inspection.
- The quality assurance framework audit for Health and Safety carried out in April 2023 incorrectly stated, "All staff are first aid trained," However the training matrix shared by the manager identifies 4 staff have not had first aid training and 1 staff member is out of date for first aid training.
- The same audit incorrectly stated, "All residents have weight measured on a monthly basis and are aware when residents need additional supplements." However, records showed 1 person's weight was last recorded in February 2023 and this was not identified at audit. This meant the audit had not been completed accurately.
- The medication audit completed in April 2023 identified medication stock audits were not regularly completed, this had not been improved and we found prescribed cream was not available for 1 person.
- The well-led audit carried out by the provider in April 2023 identified compliance with training needed to be improved. We found the same concern during our inspection. Action had not been taken to ensure all staff were compliant with the training expectations of the provider.
- There was no evidence of infection control audits.

The failure to operate effective systems to assess, monitor and improve the service, was a continued breach

of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We spoke to the provider about our concerns, they told us they thought things had not improved because there was not a consistent manager in post. They felt things would improve now the manager was in post. We asked what improvements would be made to their governance systems. They told us they thought the current system would be more effective with the manager in place.

At the last inspection the provider failed to notify the Care Quality Commission of significant events. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At this inspection enough improvement had been made and the provider was no longer in breach of Regulation 18.

● Significant events were notified to CQC in a timely manner.

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 the last inspection the provider failed to act in an open and transparent way. This was a breach of Regulation 20 of the Health and Social Care Act 2008.

At this inspection enough improvement had been made and the provider was no longer in breach of Regulation 20. However, further improvement was required to ensure relatives were kept fully informed.

● The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents and incidents occurred.
● When concerns were received, they were recorded and dealt with in line with the provider's policy.
● A relative told us about 2 safeguarding incidents which had occurred, they told us, "I wanted a report about what happened and never got anything back."
● Most relatives told us they were informed when things go wrong. One relative told us, "Lots of times we will ring, and they say [person's name] is fine, but we pick [person's name] up and see they are not fine because something has happened." The relative added they had been informed of an incident recently.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People, their relatives and staff were not always engaged and involved; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.
● There continued to be a lack of robust systems in place to evidence people were supported to express and review how they wanted their care to be provided. People were not given regular opportunity to discuss their individual care needs or any issues they had in the home. However, their individual needs and circumstances were considered when they were developed by staff.
● Team meeting minutes were provided by the manager following the onsite inspection. Team meeting minutes dated October and December 2022 were both created on 19 January 2023. A third team meeting was shared which was completed and created in September 2022.
● The meeting minutes were brief, for example the meeting in September reminded staff to complete e-learning, count medicines with 2 staff members and to count finances daily and report any medicines errors or finance errors to the manager. There was no opportunity for staff to give feedback. All 3 meeting minutes stated 'No previous minutes' and stated the meetings were being relaunched but had the name of a

different service on them.

● Some staff told us prior to the manager starting on 1 June 2023 they had not felt supported. However, staff were consistently positive about the new manager during their short time in the service, their comments included, "[Managers name] is like a breath of fresh air," "She is a good manager," and, "[Managers name] has listened to us. I've asked for cleaning products, and they have been here the next day."

● Since the last inspection relatives and staff told us people were getting out more. One staff member told us, "We are definitely on the up and things are going in the right direction. We have seen noticeable differences with the residents and are seeing their quality of life improve."

● Staff were complementary about the support they received from their colleagues.