Ashtead House Limited

Ashtead House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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
Ashtead House provides accommodation and personal care for up to 10 people who have a learning disability and autism or have a mental health diagnosis. At the time of our inspection, there were 7 people living at the service. The service was a large home, bigger than most domestic style properties. This is larger than current best practice guidance. However, the size of the service having a negative impact on people was mitigated by the building design fitting into the residential area and the other large domestic homes of a similar size.

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.

Right Support
Risk associated with people's care were not always managed well by staff. There were not sufficient staff deployed to ensure the safety of people. The service was not well maintained, and the décor was outdated.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People told us they felt safe, and staff were knowledgeable on safeguarding procedures. People had access to external health care support.

Right Care
Staff were not trained effectively, and their competencies were not assessed. Assessments of care were not completely sufficiently to ensure people's needs and preferences were considered. There were times people were not treated in a kind and respectful way. People did not have access to meaningful person-centred activities. Meals did not always look appetising, and people did not have a choice at mealtimes.

Right Culture
The recruitment of staff was not always undertaken in a robust way. There had been a lack of management oversight at the service. Systems in place to audit the service were not robust and actions were not always taken where shortfalls were identified.

Incidents and accidents were reviewed, and actions taken to mitigate the risks. There had been a delay in responding to complaints, but this was being addressed by the providers team.

Rating at last inspection and update

The last rating for this service was requires improvement (published 12 March 2020). At our last inspection we recommended that staff were supported to obtain the necessary skills to meet people's needs and to ensure documents in care plans were accurate and properly analysed. At this inspection we found the provider had not acted on these recommendations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection and based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see the 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.

The overall rating for the service has remained requires improvement based on the findings of this inspection.

Enforcement and Recommendations
At this inspection we have identified breaches in relation to people not being protected from unsafe care, staff not being appropriately trained and supervised, and people not being supported appropriately with meaningful activities. We also identified breaches in relation to dignity and respect and the lack of robust oversight.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Ashtead House

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection team was made up of 3 inspectors.

Service and service type
Ashtead House 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. Ashtead House 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. We were supported on the inspection by the regional manager and a deputy manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was 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 sought feedback from the local authority and professionals who work with the service. We used this information to plan our inspection.

During the inspection
We spoke with 3 people and 3 relatives about their experience. We spoke with 6 members of staff including the deputy manager, regional manager, and care staff. We reviewed a range of records. This included 4 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Risks associated with people's care were not always managed in a safe way. There were people at risk of dehydration. According to their care plan, 1 person's fluid intake needed to be recorded. However, there was no record of what the target of fluids needed to be although staff told us they assumed it needed to be 1500 millilitres (mls). In March 2023 there were 8 days where fluids had not been recorded. Where the person had not reached the target of 1500 mls there was no record actions had taken place to address this. This put the person at further risk of dehydration.

● People's nutritional risks were not being managed in a safe way. People were weighed monthly however where they were losing weight there was no evidence of any actions taken to address this. For example, one person had lost over 3 kilograms since December 2023. There was no information on what actions staff were taking to address this. Where another person's food intake was being recorded staff were not recording the portions of food the person was eating. This meant it would be difficult to determine whether they were eating sufficient amounts.

● Where people were at risk of choking staff were not ensuring they were supported appropriately with their meals. One person was left with their meal on a bed table and the person was leaning to the side. The member of staff did not ensure the person was sitting upright. We asked the person if they would like to be sat up and they told us they did.

● Another person was being given thickener in their drink which was the wrong consistency according to the guidance from the Speech and Language Therapist (SaLT). When staff were supporting the person to eat, they were not ensuring the chair was reclined, as per the SaLT guidance. We saw the person's chin was sitting on their chest and staff were pushing the person's head back and pushing the food between their closed lips. This increased the choking risk to the person.

● In the event of a fire, there was a risk that appropriate measures would not be in place to mitigate risk to people and staff. The fire safety folder had no nominated person allocated for overall responsibility for fire safety. There was a staff compliance form for February 2023 that staff had to sign to state they understood their responsibilities if a fire occurred. However, there were 6 staff working at the service that had not signed the form. Two people's evacuation plans had been updated but not printed off and placed in the fire grab folder. This meant they may not be supported appropriately in the event of an emergency.

The failure to ensure risks to people's safety were robustly assessed was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not sufficient staff deployed at the service which put people at risk. One relative told us, "Not

enough staff considering what they have to do, cooking, cleaning, care for residents and some need more help than others. If 1 (staff) isn't in the kitchen prepping food, then another is doing paperwork or doing the meds."

● The regional manager told us 3 care staff were required each day with an additional member of staff on duty for half of the week whose role was to drive people to activities and to provide care. Staff duties included supporting people, preparing meals, cleaning, and laundry. We found staff had little time to spend with people. On one occasion a person in bed was calling out for staff. They were not able to get their attention and started banging on their bed tray with their remote. We had to alert the regional manager as all staff were busy elsewhere.

● There were frequent occasions where people, who were at risk of falls, were sat in the living room and there were no staff present. We saw on day 2 of the inspection a person who was at risk of falls and had a room downstairs was found upstairs without staff knowing the person had gone up there.

● Staff fed back there were not enough staff to support people. Comments included, "It's not sufficient, sometimes we can't get to do things with the service users. For example, one member of staff has to be with (person) when going to the toilet. Someone has to be doing laundry. I think four would be better every day" and "Not enough staff. Sometimes you have to work with agency and its stressful and the person (staff member) is new."

The failure to ensure there were sufficient staff deployed at the service was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not always operate safe recruitment practices when employing new staff. We noted from 1 recruitment file there was a lack of detail around where they worked for a period of 13 years other than to say the type of work it was. This was despite the member of staff being required to provide a full employment history so that the employer could confirm whether there were gaps in line with the legal requirements.

● Appropriate references had not always been sought for staff. The same member of staff also worked for 3 health care providers in a short time yet only 1 of these providers had been contacted for references. In another recruitment file we noted there was only 1 reference, and this was a pre-written letter dating back to 2019. This was despite the member of staff working for another care provider after this date. The provider failed to seek a reference from this care provider so they could check the member of staff's performance in this role.

The failure to ensure robust checks were undertaken before staff were employed was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The third recruitment file contained all the relevant information including a full work history and appropriate references. All files had evidence of the staff identity and completed health questionnaires. Checks with the disclosure and barring service (DBS) had also been undertaken with all of the staff. DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people.

Using medicines safely

● There were elements to the management of medicines that were unsafe. We observed 1 person's prescribed thickener was stored in a kitchen cabinet. This meant there was a risk other people may be harmed by accidentally swallowing the powder. We fed this back and on day 2 we saw this was being stored in the medicine cupboard.

● One person was prescribed regular anti-psychotic medicine. They also had an 'as and when' prescription

for additional anti-psychotic medicine if required. However, the 'as and when' guidance was not clear on the limits of how much the person could have over a 24-hour period. This meant there was a risk staff would administer more than was safe to do so. We fed this back to the regional manager who told us they would update the guidance.
● Other elements to the management of medicines were safe. The medicine administration record (MAR) had a dated picture of the person and details of allergies, and other appropriate information, for example, if the person had swallowing difficulties.
● Where medicines were not given, there was information on MAR for the reasons, for example, the person being in hospital.
● There were other medicines prescribed 'as required' and these had protocols for their use.
● A medicine audit was undertaken regularly, and all of the staff had been competency assessed to ensure that they had the skills required to administer medicines.

Learning lessons when things go wrong
● Incidents and accidents were recorded with action taken to reduce further occurrences. Staff also understood their responsibilities when an incident occurred. One member of staff told us, "We record it and then report it to the manager."
● We reviewed the incidents and accidents and found that steps had been taken to reduce the risks of them happening again. For example, where people had incidents of anxiety, they were referred to the appropriate health care professionals and monitoring charts were completed.

Systems and processes to safeguard people from the risk of abuse
● People we spoke with told us that they felt safe living at the service. One relative told us, "Never been any safeguarding issue since he has been there."
● Staff received safeguarding training and there was a whistleblowing policy that staff could access. Staff told us they would not hold back on whistleblowing if they had a concern. One told us, "I would speak to the person (victim) who is involved to see if they open up to me and then I will record it. I would report it to the manager."
● We saw that where there were any concerns raised, the regional manager would refer this to the Local Authority and undertake a full investigation.

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. There were areas of the home that were not clean including touch points on doors, skirting and door frames and cabinets in the kitchen. One relative said, "I would say it could be slightly cleaner. There is quite a lot of dust around." We raised this with the regional manager who told us they would address this.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that 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 was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

The care homes approach for visitors was in line with current government guidance. People and their relatives were positive about their experience of visiting and being able to see their families.

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. At this inspection the rating has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● At the last inspection we recommended the provider supported staff to obtain the necessary skills to meet the needs of the people they care for and support. At this inspection we found continued concerns around staff competency.

● Relatives did not always feel staff were appropriately trained. One relative told us, "New staff are not trained well. I feel like sometimes they are put in the deep end and not trained efficiently in certain sections and have to learn on the job."

● The provider had failed to ensure suitably qualified and skilled staff were deployed to meet people's needs. The majority of staff had received the mandatory training however we found this was not effective in ensuring staff understood their role. Staff had a lack of understanding of the medical conditions people had. There were people with diabetes however staff supporting them did not have an understanding of the signs to look out for should the person become unwell. Staff also had a lack of understanding of people's mental health diagnosis.

● The service supported autistic people however staff we spoke with had a lack of understanding of what this was. One member of staff told us, "It's not a normal function in their brain." They were unable to tell us how this affected people's communication and interaction with the world. Another member of staff told us, "I don't think I have done training."

● Care staff had not always received appropriate support that promoted their professional development and assessed their competencies. The service policy stated staff were required to have 6 one to one meetings with their manager in a year. According to the supervision records only 2 members of staff had received a supervision since 2021.

● Although these one to ones were now being organised, there were missed opportunities for the provider to have conversations with staff around any areas for improvement. One member of staff said, "I would like them more frequently so you can talk to them about what is happening and what is good."

The provider failed to ensure there was adequate training, knowledge and competency checks which is a 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

● People moved into the service before the provider and staff had time to fully assess their needs. We noted from 1 person's pre-admission assessment there was a lack of information on their needs. Where it asked whether the person had problems with their mobility, its stated 'yes' but with no further detail. It stated the person was doubly incontinent however the regional manager told us this was not the case. There was no

information on why the person was moving in. This meant the provider could not be assured they were fully able to meet the person's needs.

● Care and support was not always planned in line with current evidence-based guidance. The service standards failed to incorporate relevant guidance that was specific to the services they provided. For example, people were weighed monthly however there were no Malnutrition Universal Screening Tools (MUST) used to determine whether their weights were at a healthy level for them.

● There were people who had lived at the service many years and whilst there had been an assessment of their needs and choices this was not reviewed regularly. Staff told us people were allocated a key worker. The key workers role was to meet with people once a month to review their care to ensure it met with their needs and preferences. One member of staff told us, "We have meetings with the person you are key working. We talk about birthday parties, how they want you to support them." However, we did not see from the care plans these meetings were taking place.

As the provider had not ensured an assessment of the needs and preferences for care and treatment of people was undertaken appropriately this is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to eat and drink enough to maintain a balanced diet

● Relatives fed back concerns they had about the quality of the food being provided at the service. One relative said, "The quality of the meals is not the best."

● We observed the food on offer to people did not look appetising and there lacked, nutritious fresh food available. On the day of the inspection there were 2 meal choices on the menu yet neither of these options were offered. The main meal was supposed to be fresh mackerel however there was no fresh fish available and instead people were given cheese and onion pasties and baked beans.

● Care staff were required to prepare meals and fed back there needed to be improvements on the quality of the meals provided. Comments included, "There is not enough fresh food for us to be able to make nutritious meals", "There is nothing in the fridge. We shouldn't need to get to the extent where you have a menu, and you can't implement them" and "Sometimes with the menu there is not enough food."

● One person required their meal modified. We noted the member of staff did not present the meal in an appetising way. The cheese and onion pastie was pureed with a dollop of pureed baked beans on top of the pastie. This meant the person did not have an opportunity to taste each flavour. We saw from food diaries this person was also having biscuit snacks mixed with a fruit squash rather than a more palatable option. The regional manager told us they knew the meals were not presented well and assured us they would take actions to address this.

The provider failed to ensure people were involved in the planning of their meals, not given choices and the quality of the food for people was poor. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Relatives fed back improvements were needed to improve the décor of the service. One relative said, "The upkeep of the property has gone down, it used to be nicer. It needs decorating. (Person's) bedroom could be made more homely."

● We observed areas of the service required updating and the communal areas and people's bedrooms lacked a homely feel. There was furniture in people's bedrooms that was damaged including handles and drawers and a radiator cover. In one person's room where there had been a leak in the ceiling there remained a bulge and stain in the wallpaper.

● One section of the lounge/dining room was being used as an area where staff kept paperwork and a table

and chairs where we observed them frequently writing up care notes. This took up valuable space that people could have used. Relatives had also observed this with one feeding back, "They (staff) tend to be at their station in the lounge."
● There were adapted bathrooms for people who had mobility restrictions. Where people required moving aids including hoists these were provided in their rooms.

We recommend the provider reviews and updates the service décor in line with people's likes and preferences.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Staff liaised effectively with other organisations and teams. People received support from specialised healthcare professionals when required, such as GP's, chiropodists and social workers. Feedback from staff and documentation supported this.
● Staff recognised when people were poorly and had contacted the relevant professionals. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals.
● We saw from care notes one person had become unwell and an appointment was made for them to visit the hospital. This then resulted in a referral to a specialist to look into their health concern.

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.

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.

● We observed people were asked for their consent before staff delivered care. Relatives told us they were consulted in relation to their family member's care. Comments included, "If (person) needs any jabs or medication they will contact me to get consent" and "(Person) had the covid jab and I had to give permission."
● People's rights were protected because staff acted in accordance with MCA. We saw from the care plans where people's capacity was in doubt assessments took place along with clearly recorded best interest decisions. Examples of these related to consent to living at the service and medicine administration.
● We saw where people were being restricted, capacity assessments had been undertaken and had recorded best interest meetings. Where appropriate applications had been submitted to the local authority for authorisation.
● Staff understood the principles of MCA with one member of staff telling us, "You assume everyone has capacity. You speak to a family member and the manager (if you doubt the person's capacity)."

Requires Improvement

Is the service caring?

Our findings

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

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

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

- There were times during the inspection where staff did not act in a considerate way towards people. We heard a person ask staff several times for a coat hanger so they could hang their coat up in the bedroom. However, staff ignored this request until we raised it with them. We saw the person was happy when they were given a hanger.
- Another person was getting distressed about not leaving for their planned activity. We observed a member of staff point at them and say, "You need to behave". It took another member of staff to hold the person's hands and explain the delay before the person then calmed.
- We noted a person was tearful and staff were trying to distract them. A member of staff told us the person had recently been informed of a family bereavement. We asked if the person was being supported with story boards or bereavement support of any kind and the member of staff just shrugged and said, "What can you do?" Bereaved people with a learning disability often struggle to express and articulate their grief in a meaningful way. There were no systems in place to support the person with this.
- People were not always treated in a respectful and dignified way. One person was being supported with their meal. We heard the member of staff refer to the person as, "Good boy" when they ate. The member of staff was also seen to wipe the person's mouth with the plastic apron the person was wearing rather than a soft cloth.
- During the afternoon on the first day of the inspection 2 people were sat in the lounge for approximately 45 minutes. Staff entered in and out of the lounge during this time without any of them acknowledging either person. One member of staff took their lunch break but sitting in the same room at the table and again not speaking to either person. The regional manager told us staff are encouraged to eat their meals with people or take their break in the back office.

The provider failed to ensure people were always treated in a kind, dignified and respectful way which is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives fed back there were some staff they had observed to be caring. Comments included, "(Member of staff) says take your time up the stairs. She looks after me", "They are nice and friendly to (family member)" and "They seem to be all very caring."
- We saw occasions where staff were considerate to people. One member of staff asked a person if they would like to wear their cardigan. The person smiled and responded, "Yes my dear".
- When a person became upset when they had hurt their finger staff responded in a comforting way and

reassured the person.
● There were elements to people being supported with their independence. One person told us, "Staff take my washing up the stairs for me. I put it away and fold it." During the inspection people took their plates back to the kitchen and we saw 1 person being supported to prepare lunch.

Supporting people to express their views and be involved in making decisions about their care
● People were able to decorate their room with items that were important to them including photos of their loved ones.
● Friends and family were actively encouraged to maintain relationships with people at the service.
● People made decisions about some aspects of their daily living including when they wanted to get up or go to bed. Where people chose to stay in their rooms staff respected this.

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 good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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 told us there were not sufficient meaningful activities for them to take part in. One person told us, "I just sit down and watch TV." Another said, "I would like to go out more. Like going out for meals. Sometimes I am bored. Weekends we don't go out."
- Although relatives accepted activities had reduced at the start of COVID-19 they fed back their concerns about the lack of meaningful activities for people including going out since the restrictions relaxed. Comments included, "(Person) doesn't do enough, they used to do a lot more socially. (Person) loves going to the shops, cinema as well and day centre more regularly. (Person) gets bored" and "When we ask (person) where they have gone its normally just shops. We raised concerns with activities as (person)just tends to watch TV."
- There was limited meaningful and person-centred activities offered to people. According to 1 person's care plan they enjoyed outside activities including shopping, cinema, going out for meals. According to their daily diary over 31 days they went out 16 times. This was limited to a day centre, walks and a drive to get snacks. According to another person's care plan they enjoyed outside activities of going out for a walk, going for a car ride or visits to cafes. According to their diary for the same time they did not go out for the whole of March.
- The provider had not considered the guidance around right support, right care, right culture which advises 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.
- Staff fed back that people did not have sufficient meaningful activities. Comments included, "They sometimes get bored; they don't go out enough. They don't get the positive experience" and, "I don't think they do enough activities."

Care and treatment was not provided that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People and the relatives were not always involved in the planning of their care. Comments from relatives included, "I have never seen a copy of the care plan, it would be an insight" and "Not involved in developing that (care plan). We are not involved as we were before."
- Care plans were not always detailed around people's life. One person's care plan stated they had no contact with their family but there was no other information on their life history aside from where they lived before moving into the service.

● Staff told us they were not aware of people's life histories. Comments included, "I don't know anything about (person's) family background" and "I know she (family). Not really know any more. I know why (person) struggles to communicate. It would help if I knew them more." Having this information would enable staff to engage more effectively to provide person centred care.
● One person had a 'Positive Behaviour Support' plan with strategies in place to support the person with their day to day life. However, staff were not always aware this was in place and were not following the strategies. One member of staff said they could not recall the details of the plan but they felt the strategies were not working. The regional manager told us this had not been fed back to them.

Care and treatment was not planned to reflect people's individual preferences. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The majority of the people at the service were younger adults and did not have life limiting conditions. However, we did note that questions were asked around end of life care and what family they wanted involved.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Staff had not always considered people's individual needs to communicate with people in ways they understood. We did not observe staff using accessible ways to communicate with people during our visits despite a member of staff telling us, "One person does not talk verbally so we use signs and pictures."
● One person's communication plan stated they communicated using an electronic communication aid. However, when we initially went to speak with the person staff had not ensured the machine was fully charged which delayed the person being able to communicate effectively.
● Another person's care plan stated the person may not respond if staff are talking too quietly, staff were to ensure they spoke clearly to them to ensure they had full understanding. We did not see staff try and engage with the person in this way. Another communication plan for a person stated staff were to encourage the person with writing down things to improve their communication. We did not observe staff interact with the person in this way.
● Although there was a complaints policy in picture format the menu choices were just in small print and hanging in the kitchen which was not accessible for people.

As the provider failed to ensure people were supported to be able to communicate so they understood choices around care this is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● Complaints had not always been responded to in a timely way. One person fed back to us they had made a complaint about staff conduct. They told us although this had been discussed with the previous manager, they had not had any feedback on how this had been concluded. This also left them feeling not confident in raising concerns in the future.
● Relatives we spoke with told us complaints they raised took some time to get resolved which left them feeling frustrated. One relative said, "It has only just been resolved almost a year later. It has been resolved

now but I had had enough."

● As there had been changes in management there was not a robust system of recording complaints and concerns. The regional manager was now addressing this, and we noted that any outstanding complaints were being addressed by them.

● There was a complaints procedure displayed in the hallway, that was in an easy read format to meet the needs of people.

Inadequate

Is the service well-led?

Our findings

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

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

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; Continuous learning and improving care

- The provider has failed to ensure their legal responsibilities to have a registered manager at the service. The previous manager had left the service in May 2022 and there had been no successful applications for another manager to register since this time. The regional manager advised us they had tried to take steps to recruit a new manager, but this had not been successful.
- The provider was also supporting people with a mental health diagnosis. However, their Statement of Purpose (SOP) did not include this. The SOP helps us to identify any specialist services a provider intends to provide, so that we can make sure they can meet those needs.
- People were not being supported to lead meaningful and empowered lives. There was a lack of management and provider oversight to ensure people had access to activities that were important to them.
- Relatives fed back their concerns about the management of the service and the lack of communication. One relative said, "Lack of management was really bad. I think if affects them (people) all." Another said, "Personally I don't know who is in charge."
- There was a mixed response from staff about the leadership. One member of staff said, "The staff group are divided." They said of the regional manager, "She treats everyone equally. She will listen to you." Another member of staff said, "I don't know about management." They said the current management arrangements lacked direction.
- Systems in place to monitor the delivery of care were not robust and this impacted on the care that people received. There had been an audit undertaken by a member of the provider's quality team in February 2023. Areas identified for improvement had not all been addressed. For example, it had been identified people were not involved in the meal planning and not offered choices. It was identified that key worker meetings were not being recorded. We found neither of these had been addressed.
- At the previous inspection we recommended the provider improve the quality and accuracy of care records. At this inspection we found this had not improved. People's care plans referred to out of date information on when they last attended health appointments and references to activities that had reduced due to COVID. Daily notes were not always recording when people went to bed including a person that required repositioning. This meant night staff may not be providing the most appropriate care.

The failure to ensure quality assurance and governance systems were effective was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The provider has taken steps to increase management oversight of the service including a regional manager being present at the home more frequently. The provider also sent us an action plan to address shortfalls at the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There had been no formal surveys to gain feedback sent to people and their representatives. Comments from relatives included, "I think I have only been asked once" and "I do not recall ever having a survey, anything to improve communication." However, the regional manager told us they had taken action to address this, and surveys were now being sent out.

● It had been identified through a provider audit in February 2023 there had been a lack of resident meetings with people. As a result, we saw a resident meeting took place just prior to our inspection where discussions took place around activities they would like to do and meals they wanted to prepare.

● There were varied responses from staff on whether they felt supported and valued. Comments included, "What I want in a job is to be feel like the urge to go to work. I don't feel that at the moment", "I don't know whether I feel valued" and "They listen to my opinions."

● The regional manager told us there were plans to in place to allocate lead roles to staff to make them feel more empowered. They told us they were aware of the shortfalls over leadership and were introducing more frequent meetings with staff to gain their input and feedback.

Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The regional manager worked well with the healthcare and social care professionals involved in the care of the people who used the service. This included care coordinators, dentist, GP? surgery, social services and pharmacists.

● The provider had informed the CQC of significant events in a timely way, such as when people had passed away, where there had been suspected abuse and any significant injury. This meant we could check appropriate action had been taken.

● The regional manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guideline's providers must follow if things go wrong with care and treatment.

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 not ensured an assessment of the needs and preferences for care and treatment of people was undertaken appropriately. People were not supported to be able to communicate so they understood choices around care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks to people's safety were robustly assessed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure quality assurance and governance systems were effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 19 HSCA RA Regulations 2014 Fit and

personal care	proper persons employed The provider failed to ensure robust checks were undertaken before staff were employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there was adequate staff deployed and training, knowledge and competency checks were undertaken.