

Community Homes of Intensive Care and Education Limited

Redlands

Inspection report

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Redlands is a residential care home providing personal care to seven people at the time of the inspection. The home can accommodate up to eight people in one building and there are multiple shared spaces. They predominately support people living with a learning disability and/or autism.

People's experience of using this service and what we found

The provider had not established an effective system to ensure people were protected from the risk of abuse. Risks to people's health and wellbeing had not been monitored or mitigated effectively. People were at risk of harm because staff did not always have the information, they needed to support people safely. At our last inspection we found safeguarding incidents had not always been reported as required to the local authority. At this inspection we identified a continued lack of reporting of safeguarding incidents. Care plans and risk assessments lacked sufficient detail to ensure people were supported safely.

People were not supported to have maximum choice and control of their lives. We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. The provider was not able to demonstrate how they were meeting the underpinning principles of right support, right care right culture. The service was not maximising people's choices, control or independence. People were not always supported to make meaningful choices. There was a lack of person-centred care and people's human rights were not always upheld. A lack of timely action by leaders to ensure safeguarding incidents were responded to meant people did not lead inclusive or empowered lives. People had care plans in place. However, these were not always written in a way that was person centred and easy to understand; we found inconsistencies in care plans, a lack of detail and care plans which had not been updated to reflect the current support people were receiving. We observed people were not always supported in an open, inclusive and empowering way.

The service was not well led. At our last inspection the quality assurance systems to assess and monitor the service were not always in place, and where they were, they were not effective. At this inspection we found the provider did not have enough oversight of the service to ensure it was being managed safely and quality maintained. Quality assurance processes had not identified all of the concerns in the service. Records were not always complete. Indicators of a closed culture were identified, and staff morale was low. This meant people did not always receive high quality care. The provider had failed to notify CQC of significant events that happened in the service as required by law.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 8 October 2020) 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

We received concerns in relation to the safeguarding processes within the service. As a result, we made the decision to undertake a focused inspection to review the key questions of safe and well-led only. We inspected and found there were additional concerns, so we widened the scope of the inspection to become a comprehensive inspection which included all five key questions.

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 see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations

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

We have identified breaches in relation to staffing, person-centred care, safe care and treatment, management of risk, safeguarding people from abuse, premises and equipment, assessing and monitoring risk, good governance and failure to report to CQC.

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

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

Follow up

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service effective?

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.

Redlands

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 conducted by two inspectors, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. For this inspection the Expert by Experience worked remotely to contact relatives for their feedback about the service.

Service and service type

Redlands 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. Redlands 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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.

During the inspection

We carried out observations of people's experiences throughout the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke to three people who used the service about their experience of the care provided. We spoke with eight members of staff including two area managers, the registered manager, deputy manager, positive behavioural support therapist and care workers, including agency care workers. We spoke to one professional about their experience of the care provided. We reviewed a range of records. This included positive behavioural support plans and medicines records for four people. We looked at five staff files in relation to recruitment and three agency staff profiles. We also reviewed a variety of records relating to the management of the service.

After the inspection

We spoke to six relatives about their experience of the care provided and received feedback from four members of staff. We reviewed a range of records. This included two people's care records and a variety of records relating to the management of the service, including risk assessments, quality assurance records, training data and policies and procedures. We continued to seek clarification from the provider to validate evidence found.

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.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had 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.

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

- The provider did not have effective systems and processes to safeguard people from the risk of abuse.
- At our last inspection we found safeguarding incidents had not always been reported and acted on as required to the local authority. At this inspection we identified a continued lack of reporting of safeguarding incidents. For example, from a review of records we identified two safeguarding incidents which had not been explored or investigated by the provider and were not referred to the local authority safeguarding team. We asked the registered manager to submit retrospective notifications for these incidents.
- People were not protected from the risk of financial abuse. We found discrepancies within people's financial records which had not been identified by the provider. We spoke to one of the area managers about this who told us they would investigate the discrepancies and share their findings. We raised our concerns with the local authority safeguarding team.

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.

During the inspection the provider started to take action in response to the concerns raised with them; retrospective notifications were submitted to the local safeguarding authority team and CQC, a comprehensive review of records relating to incidents was carried out by the provider to identify any further concerns and a full financial audit of all finances within the service was carried out as well as notifications made to the police, safeguarding adults team and CQC.

- Staff understood their safeguarding responsibilities and told us they felt any concerns they raised would be looked into by the provider. One staff member told us, "I feel like there is always somewhere I can go and we get reminded of that quite frequently in team meetings."

Assessing risk, safety monitoring and management

- We found risks to people were not managed safely. The provider had not fully recognised the risks faced by people living in the service.
- There were processes in place for incidents to be recorded, reviewed and monitored where people's

behaviours could challenge themselves or others, including where restrictive interventions were used.. However, we found these processes were not effective. For example, we found recorded instances where the use of physical interventions had been used by staff and had not been reviewed or analysed through these processes. This meant the data reviewed as part of the analysis on the use of physical interventions within the service was inaccurate as they did not include all uses of physical interventions. This meant the monitoring and review process was ineffective and impacted any learning opportunities to reduce the likelihood of incidents reoccurring. In addition, we saw no evidence of any de-briefs being offered to people or staff involved in incidents.

- Care plans were in date. However, we found several concerns relating to the quality of the care plans and risk assessments. Such as; care plans and risk assessments not always containing enough detail to ensure people were supported safely, some care plans containing out of date information and not reflecting the support being provided to people and some care plans containing contradictory information.
- For example, one person's care plan in relation to their health condition lacked sufficient detail to ensure the person was supported to manage their condition effectively, one person's care planning documentation in relation to bowel management support contained conflicting information in three different care plans. One person had a health diagnosis which required specific support. This was not included on the summary which was shared with new staff. This meant new staff may not be aware of their condition putting them at risk of harm. In addition, the feedback we received, along with our observations, demonstrated the support being provided to people was not always reflective of the care planning documentation in place.
- We found risk assessments did not always contain enough detail to ensure people were supported safely, contained information which was not accurate at the time of the inspection or for some observed risks, no risk assessment was in place.
- For example, two people were identified as at risk of falls. For one person, their care plan detailed that as their health condition deteriorated, their mobility would be significantly impacted. There was no clear falls protocol in place within the service and the risk assessments in relation to falls were not sufficiently detailed. We spoke to the registered manager about how falls management could be more robust. However, we were told, "In the event of a fall that stuff would happen as common sense." They told us they believed staff had responded appropriately in the past to falls and felt this would continue. We were concerned there was a lack of guidance for staff to follow in the event of a fall to ensure appropriate action would consistently be taken.
- Another example, we observed the use of a portable heater in shared spaces. There was no risk assessment to ensure this was used safely. Another example included an emergency contingency planning risk assessment which detailed items which staff were to use if required in that situation. These items were not available within the service at the time of the inspection.

The failure to assess and do all that is reasonably practicable to mitigate risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the provider started to take action to address some of these concerns; they began to update care planning documentation, removed the portable heater from use and reviewed the emergency contingency risk assessment.

- There were concerns in relation to the environment and health and safety.
- Equipment systems, such as fire systems, were in place with maintenance and services in place. However, we found not all required checks were completed consistently. For example, the weekly cold-water checks. We observed there were some checks that had been completed which would have required further action at the time of the checks. There was no documented evidence this action had been taken. For example, we observed some recorded temperatures in relation to the hot water checks which should have triggered an

immediate management response. From the recordings we observed it took almost a week for the concern to be rectified. The registered manager told us they had been made aware at the time and took prompt action to report this to the external contractor for support to resolve the concern. However, there were no records evidencing this action had been taken.

- There was a current fire risk assessment, personal emergency evacuation plans for people and evidence of regular fire tests and drills. However, we identified potential fire hazards within the service and were concerned about the approach to fire risk management. For example, an electric heater had a visible layer of dust coating it with a sign on the wall above it indicating it was switched on each evening. The portable heater observed used in shared spaces had broken feet and the heater wire was observed to be bent and taking the weight of the heater.
- There were poorly maintained areas of the home with dirty fixtures and fittings. For example, we observed a hole in a corner of a wall which had some metal exposed.
- Areas of the home were not clean. There was a visual build-up of dust and dirt on some skirting boards, corners of rooms, marks on the walls (which included dried liquids) and dust on an electric heater. Comments from relatives included, "It is basically clean" and "It's cleaner since [assistant manager's name] started." One relative told us, "I clean the bathroom floor sometimes as it's grubby, and I wash the floor and do the dusting, and I change the bedding."
- Care staff told us they were responsible for cleaning the home and how difficult they found this at times as they would run out of time to complete any deep cleaning. Their priorities would be providing support to people. The registered manager acknowledged the challenges faced by staff to complete cleaning on top of their other tasks.

The failure to ensure the premises was clean, properly maintained and secure was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was aware of some of the concerns identified prior to the inspection and had some new furniture on order and plans to redecorate one of the shared spaces rooms. When made aware of some of the maintenance concerns they told us they had reported these for action by their maintenance team.

Staffing and recruitment

- We could not be assured the service were always following safe recruitment practices.
- We looked at a sample of recruitment files for care workers that been employed in the past year which showed that appropriate checks had not always been undertaken prior to them being employed. For example, for two people there were gaps in their employment histories and for one person who had previously been employed to work with children, there was no evidence a reference had been sought from that employer. Schedule 3 (4)(b) and (7) of the Health and Social Care Act (Regulated Activities) Regulations 2014 requires providers to make available to CQC satisfactory evidence of conduct in previous employment concerned with the provision of services relating to children or vulnerable adults and a full employment history.

The failure to follow safe recruitment procedures was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager told us they met people's commissioned hours and explained due to a recent admission into the home they now required the use of agency staff.
- Relatives and staff told us there was high turnover of staff and not always enough staff to support activities. One relative told us, "There's a bit of turnover of staff...it upsets him a bit" and "There are young staff who just don't know what they're doing." Another relative told us, "I say to show me his activities for the

week, but they're short staffed so can't do them." Another relative told us, "Sometimes there are not enough staff on."

- During the inspection we observed the number of staff on duty matched the rota. There was one occasion where there was a short notice absence which the registered manager covered until a replacement staff member arrived.

Using medicines safely

- People received the correct medicines at the right time.
- There were effective medicines systems in place for the administration, storage and record keeping in relation to medicines.
- The provider had implemented an innovative way to administer medicines safely when people chose to have their prescribed medicines in shared spaces. They used a portable lockable container. We observed how effective this was in practice.
- People had PRN protocols in place which were detailed.

Preventing and controlling infection

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The premises were not hygienic.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- 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 accessing testing for people using the service and staff.
- 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 provider facilitated visits for people with their relatives and friends in accordance with government guidance. People confirmed they were able to see their relatives and speak to them on the phone when they wanted to. One relative told us, "There are nice touches like one staff who does video calls, and they contact us on WhatsApp, which is really nice. I don't drive so they pick me up from the station and take me to the house" and "During COVID we had video calls, and on the phone, we talked for as long as we wanted." Comments from other relatives included, "I sit in her bedroom or if it's nice we sit in the garden or the shed" and "I visit when I like but I do ring before coming."
- However, one relative told us, "After COVID they've not been able to facilitate bringing her home, as she came once a fortnight in the past, and it is something to work on." They told us they felt this was because they don't always have enough staff who can drive.

Learning lessons when things go wrong

- Systems in place to promote staff learning and development were ineffective. We were concerned staff did not always recognise incidents and report them appropriately. Whilst some accidents and incidents had been reported by staff, we were not assured all accidents and incidents were reported. During the inspection we observed a fall by one person. This fall was not reported to the management team.
- The registered manager did not always investigate incidents and identify any lessons to be learnt. There was a lack of analysis of trends and patterns in relation to accidents and incidents. We observed there had been some accidents and incidents which had not had any follow-up, response or investigation by the registered manager. For example, we observed there had been incidents where injuries had been received

by staff when supporting people and there was no evidence of any de-briefs with staff to identify any lessons learnt, wellbeing checks or a review of any relevant care plans or risk assessments.

- Another example included an incident concerning a fall; the identified action taken in response by the management team was to increase the frequency of night checks for the person. The provider was unable to provide any documented evidence this action had been implemented, only verbal assurances. However, the recording form for the night checks had not been amended following the fall, no additional recording forms been put into place and there was no evidence staff had been informed of the change to the frequency in night checks for this person. We were told staff had been informed verbally but that this had not been documented anywhere, such as in the service's communication book or in a team meeting. The care plan for this person did not provide any detail in relation to the change in frequency of checks over night following the fall. We were concerned this action had not been implemented effectively.

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 good. At this inspection the rating has changed to 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

- The provider had not ensured there were enough numbers of suitably competent and skilled staff deployed effectively to support people safely. However, they told us due to a recent admission to the home they required support from agency staff. We observed there was a heavy reliance on agency staff and found no evidence of a structured or recorded induction for agency staff. We were told agency staff received a verbal induction into the service, a tour of the service and people's summaries to read. This meant the provider was not able to demonstrate agency staff received a consistent induction into the service with the relevant information they needed to support people safely. This risk was increased by the summaries for people not always containing all essential information, which has been reported on in more detail in the safe domain of the report.
- Some staff told us the increase in agency staff had impacted on people. One staff member told us, "The amount of agency staff we have, and un-trained staff coming in, is the only problem. A lot more behaviour observation charts." Another staff member told us, "We are definitely seeing a lot more behaviours as we don't have enough staff to look after the guys...it's easily preventable if enough staff and 1:1 for each person but we just can't do it this way with agency staff as they come in and don't know or sit on their phone."
- There were identified support strategies in place to support incidents where people's behaviours could challenge themselves or others safely. These strategies included the potential use of physical interventions as a last resort, to be carried out by trained staff only. The registered manager told us agency staff were not required to be trained in these interventions as they had identified a minimum of two trained staff only were required to be available to support if necessary. We were told the rationale for this decision was because if the most restrictive physical intervention were required it would only need two staff, that this restrictive intervention was rarely required to be used and that there was an established staff team in place. Therefore, they had identified this as a low risk and only a minimum of two trained staff in physical interventions was required to ensure safe staffing levels.
- However, the provider was unable to demonstrate they had considered, and mitigated, the potential risks of more than two staff being required to support more than one person in an incident, the increased use of agency staff who were less familiar to people or the impact for people being supported by less familiar staff with care planning documentation which lacked sufficient clarity and detail. There was a concern people's anxiety could be heightened if supported inconsistently by people who are not as familiar to them, their preferences and needs. This meant there was an increased risk in the likelihood of incidents where people's behaviours could challenge themselves or others. One staff member told us, "We have had loads of people leave which has created a problem for us, we've had to use lots of agency staff which is lots of new faces for service users."

- Although we were told it was rare physical interventions requiring two staff were required, we identified concerns with the monitoring and record keeping relating to the use of physical interventions and their accuracy. This meant there was a risk not all use of physical interventions was recorded, and the recorded frequency of use was inaccurate.
- At the time of the inspection, all the people living at Redlands required support when accessing the community by at least one staff member trained in the physical interventions which would also limit what the person could do and access in the community. This meant on occasions where there were only two trained staff available in the service, people were unable to access the community. The registered manager told us it was rare there would be only two trained staff available. However, they did not have any processes in place to monitor or review how often this impacted on people. Staff generally agreed the use of physical interventions was not frequent. However, they highlighted their concerns incidents could escalate when untrained staff were supporting people and they had to be alert and ready to intervene to deescalate using proactive measures.
- We observed instances where the more experienced staff were in the position of trying to provide 1:1 support to an individual, whilst also trying to oversee the 1:1 support being provided to other individuals by less experienced staff. There were occasions where multiple people required support simultaneously and the more experienced staff member was placed in a position where they had to direct the other staff and make a decision as to who required their support the most in that moment. Staff we spoke to told us they found such situations stressful and we observed how their body language, tone of voice and communication changed; they appeared stressed.
- Staff were not all trained or had the relevant knowledge to meet people's communication needs, for example, not all staff were trained in Makaton which is a form of sign language. We reviewed the training matrix and found not all training had been delivered for staff to be able to fulfil their role effectively. This included, PROACT SCIPrUK, fire practical, medication assessment and legionella awareness. We were concerned PROACT SCIPrUK showed a 22% completion rate for the service. PROACT SCIPrUK training teaches proactive strategies to support personal development and minimise crises intervention. We discussed this with the provider who told us how COVID-19 had impacted on their ability to access face-to-face training. They told us the trainers for this course had produced an on-line video for staff to watch to mitigate the risks of not having this training. However, the provider was not able to provide evidence of which staff members had watched the video. This meant they were not able to demonstrate they had mitigated the risks.
- Staff employed directly by the service received a formal induction into the service. However, we found records relating to induction were not always consistently completed.

The failure to have sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider arranged training for staff in PROACT SCIPrUK promptly which took place during the second week of the inspection.

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

- Care and support plans did not always reflect people's needs. Not all people had relevant assessments in place, such as communication and sensory assessments. Understanding people's communication and/or sensory needs is fundamental to planning and delivering good quality person-centred care. We observed the use of communication methods varied. For example, we observed one person using signs but saw very little staff using signs to support their speech.
- We observed inconsistent support being offered to people. For example, in relation to moving and handling. Such as, inconsistent approaches and poor moving and handling practices. There was insufficient

guidance available to ensure people were always supported safely, consistently and in the way they preferred to be supported.

- We observed people engaging with intensive interaction and initiating this with staff they appeared comfortable with. Intensive interaction is an approach that is used to develop positive social communication and interactions with people who have communication or social impairments. Not all staff were trained in intensive interaction. There was not sufficiently detailed guidance available for staff for some of the types of physical interactions observed and this could place people at an increased risk of harm. There was also a risk staff unfamiliar with intensive interaction may not recognise if a person was attempting to initiate intensive interaction. The area manager told us the organisation had an intensive interaction policy, and an appropriate touch policy, which they would make available to all staff, including agency staff promptly. In addition, they told us they had planned 'All about me' workshops for staff, including agency staff.

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

- People confirmed they were happy with their rooms. People's rooms were personalised. Some people told us, and evidence seen reflected this, they had been involved in making decisions about their bedrooms and the décor. However, the shared spaces of the home were mostly sparse and noisy. For people who wanted quieter areas they had to utilise the kitchen or their bedrooms. Whilst there was a sensory room, this was not a welcoming environment; parts of it had been used for storage. The shared spaces appeared to have been designed around the sensory needs of one person and didn't appear to meet everyone's sensory needs.
- Relatives told us they had concerns about the shared spaces within the home. Comments included, "I think there is a lack of comfort in the house. I know furniture gets damaged, but it does take a lot of time coming when it has been ordered and I think it's the management. I feel there is a lot more comfort needed", "She doesn't spend much time in her bedroom, but in a quiet room that's not particularly comfortable", "It's the actual furnishings I don't like because it all seems a bit bleak to me" and "They have a sensory room outside but never use it as there's no carpet."
- Staff also shared their concerns about the environment. One staff member told us, "Would like to see a bit more money spent on our home. It's been neglected."
- Initial assessments were completed when people first began to use the service. The provider had recently supported a person to move into the home as an emergency admission. A professional who was involved with supporting the person told us how positive the move had been for them and how helpful and supportive the provider had been in ensuring the move was as successful as possible.

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

- Staff mainly prepared and cooked most meals. We observed some people being offered opportunities to make their own drinks, but this was not consistently offered. One relative told us, "I think she is able to eat when she wants, and she asks for a drink ... they try to keep a healthy diet with plenty of fluids and they have tuckboxes for snacks." Another relative commented, "He can take food and drinks if he wants from the kitchen ... [registered manager's name] is very good with budgeting for the food."
- Menus were decided weekly and we were told how the staff member would sit with people and discuss and decide the menu options. People were offered alternatives if they did not like the meal choice on offer.
- Most people were supported with their dietary needs and preferences. For example, meat substitutes were available for people who had chosen to not eat meat. However, for one person with a health condition that was managed through diet, it was not clear if their dietary needs were being fully met. Their care planning documentation in relation to this lacked enough detail and the records relating to food and fluid intake were not sufficiently detailed to demonstrate their dietary needs were fully supported.

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

- Some relatives told us they were concerned about the lack of action by the provider to respond to people's health needs. One relative told us, "The dentist and opticians, they did say [person's name] was going to go but [person's name] didn't go. They're not on the ball with that."
- Another relative told us, "There always is potential for more because the occupational therapist we employed privately made recommendations but the people working there are not qualified to be able to help her develop skills."
- People had been supported to access their GP. For example, to access vaccinations if they wanted and for medicine reviews. One relative told us, "[Registered manager's name] hasn't included me in medicines reviews for a while but the doctor comes out and I talk to him."

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.

- Staff we spoke with were familiar with the term MCA and what it meant in terms of their day to day role. One relative told us, "There are occasions where she's refused to come out of her room or get dressed, and they go with it really, as it takes time and chat, like 'Hey, [person's name], what shall we do today?' They don't force her."
- For people that the service assessed as lacking mental capacity for certain decisions, there were some recorded assessments and best interest decisions. However, these had not been consistently completed. For example, for one person following an MCA, there was no evidence a best interests meeting had been held; the decision had been made by the person who had carried out the MCA and there was no evidence anyone else, including the person and any relevant views they may have had, had been involved.
- The provider had made appropriate DoLS applications and had systems in place to renew and meet any recommendations of authorised applications.

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

- Feedback from relatives was mixed in relation to the caring attitude of staff and the actual delivery of care. Positive comments included, "The core staff know what she likes to do, and what she likes to eat, how she likes to organise her routine.", "I'd say they are very kind and caring from what I've observed." and "It's excellent because it's so individualised, and extremely caring staff who can't do enough to help her."
- However, other comments included, "Some days care is good, but it depends on what care staff are on", "The young staff flirt with each other and I say 'Can you give [person's name] attention?'" and "It's okay generally but there not a lot of happy and laughing, but there is a lot of flirting."
- We saw some positive interactions between people and staff. Staff mostly spoke passionately about people. People were supported and encouraged to take the lead on tours of their home, and they appeared comfortable and engaged with this. One staff member told us, "I genuinely believe people who work here really care about the people 100%."
- Care records contained reference to people's cultural and religious preferences.

Respecting and promoting people's privacy, dignity and independence

- We observed some people being encouraged by some staff to do tasks for themselves during the inspection. Staff told us how they supported people to maintain their independence. For example, engaging in some household tasks. One person was supported to attend a local college to develop their life skills.
- Comments from relatives include, "There is a sort of routine in place where she takes laundry down she doesn't put it in the machine, and she sits in the kitchen and she assists in baking such as mixing" and "They buy her clothes with her, she picks them sometimes or they do it."
- However, people were not always supported to maintain, or develop, their independence. Care planning documentation did not always promote independence. Although there was goal planning in place, people had not been supported to be involved in identifying their goals and there was a lack of guidance in how to support people to work towards achieving their goals.
- People could personalise their room and keep their personal belongings safe. People had access to quiet areas for privacy. Staff knocked on people's doors and waited for permission before entering.
- However, people's privacy and dignity were not always supported by staff. We observed staff talking about people and their support needs in front of them, which was not always inclusive, dignified or respectful of people.
- People were being supported to widen their social networks. For example, one staff member had found a nightclub event for people to attend. They told us how people had enjoyed attending the event and they planned to make it a regular activity for people if they wanted. This would enable people to develop

friendships with people outside of the service.

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

- The provider offered people opportunities to feedback their views monthly via a pictorial survey which focussed on one key theme. Such as, food choices and activity choices.
- People had access to independent advocacy for support with specific issues.
- Staff maintained contact and shared information with those involved in supporting people. One relative told us, "They do have reviews and they report the results on the phone, but not in writing." Another relative confirmed they were involved in reviews and told us, "The care plan was being partly reviewed and we've agreed to meet again."

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.

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

- People were not always supported in an open, inclusive and empowering way. We observed instances of some staff talking about people in front of people to other staff. These conversations were not discreet, and staff did not attempt to include people into the discussions. This meant people were not treated with respect and were not being treated as adults.
- People did not always receive care that was planned, personalised or responsive to their needs. There was a lack of clear guidance and key information for staff to enable them to consistently deliver the right support to people.
- Care plans did not always reflect people's needs or strengths. Staff did not have information in how they should work with people to promote their independence. During the inspection we observed some staff completing tasks with little or no engagement with people or encouragement for them to do the task for themselves.
- People told us, and we observed, activities being offered to people. For example, arts and crafts, walks in the New Forest and sensory items. We saw people being supported to choose which activity they wanted to do. For example, which arts and crafts project they wanted or which DVD. However, activities were not consistently offered to people. We observed missed opportunities to engage people in activities.
- Some staff were observed to be responsive to people's needs and offering people opportunities to engage. However, we observed some staff were not always responsive. For example, a staff member was observed saying in front of one person, "If he takes you to the kitchen don't give him any more food as he has had enough". There was no additional context or rationale offered to explain why food was potentially being denied. Another person appeared to be distressed and was displaying the key indicators of pain as detailed in their PRN pain relief protocol. However, we observed a delay in pain relief being offered to the person, even though staff had also speculated aloud the person may be experiencing some physical discomfort.
- We observed some people frequently seeking out interaction and engagement from staff which was not responded to. We observed how some staff had to prompt other staff to offer activities and engagement to people. There were periods of time where people being supported with 1:1 support were not offered anything to do, the staff member followed the person around as they moved around the space only interacting with the person to redirect them back to one area or corner of a room. There was no communication to the person to explain why they were being redirected to the same area. One relative told us, "I'd like him to do something interesting with a one-to-one staff, because he just walks around." Another relative told us, "She does get bored."
- Feedback from relatives was mixed in relation to activities. Comments included, "There are problems with

going out as there are only two cars and they don't always have enough people who can drive", "He will grab his coat, but if there are no staff he won't go out", "She is free to walk around the houses in the garden, or go to the shed, and they take her out when they can for meals. But there are no regular activities", "It varies as to what she likes as she sometimes likes this or that and then doesn't like it, but she likes going to the beach and uses the garden in summer" and "She does have some sort of sensory toys and various things to do, with a daily structure."

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action in response to concerns raised with them during the inspection. They had started to review and update people's care planning documentation. The area manager told us we were planning to have workshops involving people and staff and would be making appropriate referrals for people. For example, to explore personalised communication tools and methods.

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.

- We saw evidence of social stories being available for people. We saw evidence of how some people had been supported to have information presented in their preferred communication method. We also saw evidence of how the provider had utilised these methods to support people to feedback about the service.

Improving care quality in response to complaints or concerns

- People and their relatives told us they knew who to speak to at the service if they had any concerns. One relative told us, "I'd go to the manager if I had to; I had a concern ... we discussed it and it was resolved." Another relative said, "I haven't had to make a complaint. I'd just see the manager or [deputy manager's name], or one of the others." Another relative said, "I complain to [registered manager's name] and he says 'I'll sort it out' but he doesn't always."
- The provider had a complaints policy and procedure in place, which detailed the timeframes within which complaints would be acknowledged and investigated. This was included in information provided to people when they started to receive a service.

End of life care and support

- No people were reported to be on end of life at the time of this inspection. However, support plans were in place which recognised people's wishes for when that time came.

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.

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

At our last inspection the provider had failed to have systems in place, or robust enough, to demonstrate safety was effectively managed. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider's oversight and governance of the service was ineffective in identifying the serious failings in relation to the safety, quality and standard of the service as detailed in the safe section of this report.
- Systems and processes to monitor the service were not robust. This meant they were not always effective, did not drive improvement and did not identify the issues we found at this inspection. Concerns were found with regards to cleanliness, safeguarding, deployment of sufficiently skilled and competent staff, recruitment processes, risks and risk management, accidents and incidents, the premises, person-centred care, failure to report and quality assurance. One relative told us, "I don't rate them well at all because they're very tight with the budget." Another relative told us, "It's an average service."
- The provider had some audits and checklists in place. There were not always completed consistently or effectively. For example, the monthly audit the registered manager completed had gaps which had not been identified. In addition, where actions had been identified, there was no evidence of identified timescales for completion, evidence of any reviews and no entries recorded to evidence when the action had been completed.
- The provider had failed to recognise or investigate incidents to prevent reoccurrences.
- The provider failed to ensure records were accurate and up to date. For example, we saw care planning documentation contained out of date information or conflicting information which meant staff did not have easily accessible current information about people. In addition, some records relating to the management of the home were incomplete. Such as cleaning schedules and water temperature checks.
- We identified concerns in relation to poor record keeping. For example, in relation to cleaning schedules, finance records, behaviour observation charts and accidents and incidents. We could see no evidence these concerns had been identified by the management team or provider until these concerns were raised during the inspection and triggered a review of some of this documentation.
- The provider had not ensured management and staff understood the principles of good quality assurance.

For example, incidents were not analysed and did not include lessons learnt to inform practice development. Information to enable monitoring was unreliable. For example, the information relating to the use of physical interventions.

- The provider failed to follow some of their own guidance within their policies and procedures to ensure quality and safety. For example, we observed two staff members during the inspection wearing nail varnish which was not in accordance with the providers infection control policy and procedure. Another example was the provider's recruitment policy and procedure; a new starter who met the criteria for an individual risk assessment did not have one.

The failure to operate effective systems to assess, monitor and improve the service, monitor and mitigate risks and maintain accurate and complete records was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was working their notice at the time of the inspection. During the inspection they made the decision to leave earlier than they had originally planned for with the provider. The area manager arranged interim cover quickly to minimise the impact for people and staff, and to ensure adequate management cover of the service day-to-day. In addition, they told us they would be visiting the service regularly to provide additional support.

- Providers are required to act in an open and transparent way when people come to harm and to notify CQC of significant events without delay.
- At this inspection we found the provider had failed to notify CQC of significant events that happened in the service as required by law. This included allegations of abuse. Such as financial abuse. The lack of reporting had not been picked up by the provider through their quality assurance processes. This meant CQC were not able to effectively monitor the service or ensure that appropriate action had been taken in relation to these incidents.

The failure to notify the Care Quality Commission of significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The area manager took appropriate action to submit retrospective notifications as soon as they became aware, they were required. In addition, they took prompt action to carry out comprehensive reviews of the documentation where concerns had been identified and initiated an investigation. They also ensured reviews were carried out in other services within the organisation who may have been impacted in a similar way.

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

- The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents and incidents occurred. Relatives confirmed they were kept informed and updated. Comments included, "If there are any changes in medication I'm told about them", "We are well informed and know what's happening" and "[Registered manager's name's] done a good job, and his communication is pretty good by email."
- During the inspection we observed the provider sent out duty of candour letters to people and relatives promptly when we made them aware of the safeguarding concerns they had failed to identify.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The culture of the service did not reflect our Right Support, Right Care, Right Culture guidance. People were not adequately supported to have maximum choice, control and independence over their lives. Care was not person-centred and the poor leadership by the provider did not ensure people led empowered lives. We observed the use of archaic and outdated terminology during our conversations with the registered manager. When we initially shared our concerns about the lack of communication tools and methods available to people, as well as the lack of sensory assessments for people, they told us people were not likely to engage in processes or be open to learning new things.
- People did not receive consistent person-centred care that was empowering, of a high quality and achieved good outcomes. Significant improvements were needed. These have been reported on in more detail in the safe domain of the report.
- While the building blended in with the local community; the lack of effective quality assurance processes meant the support provided was at risk of becoming a closed culture. A closed culture is one where people's needs are not placed at the heart of care practices and people not being involved in their support.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- It was not demonstrated people's care and support needs had been robustly assessed within the context of a shared living space, including any potential impact on other people. This showed a lack of compliance with the Right care, right support, right culture guidance.
- We received mixed feedback from people's relatives about the quality of the service and whether the care and support was person-centred. Some people were happy with the service, whilst others expressed concerns. Comments included, "I can't say enough positives about the place and the staff", "All our suggestions were acted on", "I don't think it's managed by [registered manager's name], I get more from the deputy manager", "I'm sick of saying do this or that" and "There's lots of room for improvement, with training and understanding people's conditions."
- Most relatives told us they felt communication could be improved by the provider. Comments included, "[Registered manager's name] doesn't always tell me stuff though" and "[Registered manager's name] doesn't tell me about appointments, but hopefully with a new manager that will improve."
- The provider sought feedback on the quality of the service using quality assurance surveys sent to people and relatives.
- Some staff told us they felt valued and listened to. One staff member told us, "Our assistant manager is very caring towards staff and likes to hear what we have to say." Another staff member told us, "I definitely feel listened to." Another staff member told us, "[Registered manager's name] is understanding and listens. He respects my opinion."
- However, some staff told us they did not always feel valued or listened to. One staff member told us, "We are really, really struggling. Staff morale has got so low." Another staff member told us, "I wouldn't say we have the opportunity to feedback." Other comments included, "[Registered manager's name's] communication skills lack which doesn't help with feeling supported", "I love my job but go home covered in marks and stressed. Losing so many staff, good staff going out the door and staff coming in who don't understand our service users" and "I feel we don't get much time to reflect with manager ... don't really get to speak to him."
- Systems and processes were in place to ensure staff had access to supervision and appraisal. Staff confirmed there were regular team meetings
- The service worked in partnership with health and social professionals. One relative told us, "Social workers don't come often but they do meet up at meetings and I will be there, I want to be at appointments so that they're thorough."

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Care Quality Commission of significant events.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care and support was appropriate to meet people's needs.
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 assess and do all that is reasonably practicable to mitigate risks to people.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to safeguard people from abuse and improper treatment.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the premises was

clean, properly maintained and secure.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA RA Regulations 2014 Good governance

The provider failed to operate effective systems to assess, monitor and improve the service, monitor and mitigate risks and maintain accurate and complete records.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The provider failed to follow safe recruitment procedures.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider failed to have sufficient numbers of suitably qualified, competent, skilled and experienced staff.