Allag Care Limited

Gwendolen Road Care Home

Inspection report

305 Gwendolen Road
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Leicestershire
LE5 5FP

Tel: 01162736277

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08 August 2022
09 August 2022
10 August 2022
30 August 2022

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Gwendolen Road Care Home is a residential care home providing the regulated activity of personal care to up to 14 people. The service provides support to people who primarily have a learning disability or long-term mental health condition. At the time of our inspection there were 14 people using the service.

Gwendolen Road Care Home accommodates 14 people in one adapted building.

People's experience of using this service and what we found
People were not adequately protected from the risk of harm. People were deprived of their liberty without lawful authority. Medicines were not always managed safely. Cleaning procedures within the home did not ensure a clean and hygienic environment for people.

The provider failed to work within the principles of the Mental Capacity Act 2005. The physical environment was in poor condition. People's needs were not always fully assessed and not all staff had sufficient training to support them to carry out their role effectively.

People were not always well treated and supported in a way that met their individual needs. Relatives were not always consulted in discussions about the care their loved ones received. People's privacy and dignity was not always respected.

Care plans did not demonstrate that people were able to choose who supported them and how they were supported. The service failed to support people to maintain their hobbies and interests, and provide meaningful activities, or enrichment for people to participate in. Concerns were not dealt with in a timely way.

The registered manager failed to ensure audit and governance systems were effective. Systems and processes did not support collaboration with external stakeholders and other services. Outcomes for people did not reflect the principles and values of Right Support, Right Care, Right Culture.

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

Right Care: People did not always receive care that met their individual needs and preferences. Care and treatment did not always encourage people's independence and human rights.

Right Culture: The culture of the service was not empowering for autistic people or people with a learning disability. This was because not all staff had received role specific training to enable them to work effectively. Quality assurance systems did not help the service to use lessons learned to improve quality and

care for people using the service.

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

Rating at last inspection
The last rating for this service was Good (published 16 October 2019)

Why we inspected
We received concerns in relation to people's safe care and treatment, management of incidents and lack of person-centred care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. During the inspection, further concerns were identified, and we then carried out a full comprehensive inspection of the service looking at 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 Good to Inadequate based on the findings of this inspection.
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.

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

Enforcement
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 people receiving safe care and treatment, and care that met their individual needs, people's mental capacity and consent, safe staffing levels and poor-quality management at this inspection.

Due to the concerns found during this inspection, we have sent the provider warning notices. This gives the provider a specified amount of time to make improvements to the service.

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.

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

If the provider has not made enough improvement within this 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 of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not 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.

Gwendolen Road Care Home

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 was carried out by three inspectors and an inspection manager.

Service and service type
Gwendolen Road Care Home 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. Gwendolen Road Care Home 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
At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. We telephoned the provider on the morning of the inspection to ask if anyone living at the service would be distressed by our visit. The provider advised this would not be the case and welcomed us into the home.

Inspection activity started on 8 August 2022 and ended on 30 August 2022. We visited the location's service on 8 August 2022, 9 August 2022, 10 August 2022 and 30 August 2022.

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

During the inspection
We spoke with three people who lived at the service, two relatives, and eight members of staff including the registered manager, nominated individual, care manager, deputy manager and a team leader. The nominated individual is responsible for supervising the management of the service on behalf of the provider

We reviewed four recruitment files, four care plans, and a range of other documentation including behaviour charts, daily care notes, and medicine records.

We also 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.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. 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

- People were not adequately protected from the risk of harm. Multiple safeguarding issues were identified during our inspection. These had not been identified or reported to the local safeguarding board by the provider. As a result of our inspection, we made safeguarding referrals for seven people living at the service.
- Staff stated they had received safeguarding training. However, not all staff we spoke to could clearly describe how to identify potential safeguarding concerns. Our observations confirmed staff lacked insight into safeguarding. This meant safeguarding issues had been missed, and potential safeguarding concerns may not be identified and escalated to the registered manager.
- Service users were deprived of their liberty without lawful authority. For example, one person could not consent to live at Gwendolen Road Care Home, however an application had not been submitted to the Deprivation of Liberty Safeguards Board until it was raised at the inspection. Deprivation of Liberty Safeguard conditions for another person had also not been met. This meant that service users were not always protected from abuse and improper treatment.

Failure to protect people from abuse and to deprive them of their liberty without lawful authority is a breach of Regulation 13 Safeguarding of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Assessing risk, safety monitoring and management

- Risks to people were not managed safely. Risk assessments and care plans for people who needed support when they became distressed, contained insufficient details to guide staff on how to manage this. Behaviour charts often lacked detail to determine the cause, triggers of behaviours and what action staff took to help the person become calmer.
- Risks relating to fire safety had not been identified or acted upon. For example, a person who was known to be a risk of smoking cigarettes in their bedroom, was placed in a nearby room to a person who had oxygen tanks in their bedroom. There was no fire risk assessment in place, storerooms and cupboards were full of combustible materials, and an external fire contractor identified that the space in the roof had not been compartmentalised to prevent fire spreading rapidly across the home if the fire entered the roof space. Since the inspection, the provider has cleared combustible material, and is in the process of having the roof space compartmentalised.
- Personal Emergency Evacuation Plans (PEEPS) were not easily accessible, up to date, or reflective of people's needs. There was no clear guidance for staff to support people in the event of an incident that required them to leave the building. This placed people at risk of harm in an emergency.

Using medicines safely

● Medicines were not always managed safely. We reviewed a range of medicine records. We found issues with the counting of controlled drugs. It is a legal requirement for controlled drugs to be counted and recorded at least once a day. This is to reduce the risk of theft or misuse of these controlled drugs. We raised concerns with the person in charge of medicines, who advised they would rectify the issue. However, the same issues were still present when we returned on a later date. Medicine audits had not been completed and therefore had failed to identify this issue prior to our inspection.

● People who had been prescribed 'as required' medicines, had information sheets in place to guide staff on when to give these medicines. Some people could not communicate verbally so the information sheet described how the person may behave when they were distressed or in pain. However, the information sheets described identical behaviours for both pain and distress. This meant it was not clear for staff whether the person required medicine for pain relief, or medicine for agitation. This placed people at risk of receiving the wrong medicine to meet their needs as staff were unclear about which one to administer.

● Some people required their medicines to be crushed to make it easier for them to swallow. Medicines can only be crushed with authorisation from a medical professional. This is because not all medicines can be crushed safely. Crushing medicines incorrectly may prevent the medicine from working properly or could alter how the body processes and responds to the medicine. People's prescribed medicines had changed; however, new authorisations had not been obtained. This meant staff were crushing medicines without a medical professional authorising that it was safe to do so.

● Records for people who required covert medicines were not always accurate or reflective of the method of administration. For example, one person had fluctuating capacity. They were to be openly offered their medicines at each administration time, however if they refused to take their medicines, their GP had agreed staff could hide the medicines in the person's food. This is because their medicines were deemed essential to the person's health and wellbeing. Systems and processes meant staff did not record whether the person had taken their medicines openly, or if they had received them covertly. This meant staff were unable to identify any deterioration in a person's capacity to consent to taking their medicines openly.

Learning lessons when things go wrong

● Lessons were not always learnt when things went wrong. For example, we raised poor staff practice with the nominated individual at the beginning of the inspection. When we returned for the final day of inspection, no improvements had been made and the person we raised concerns about was still experiencing unnecessary distress.

● The provider failed to have an effective and robust system for identifying concerns, looking for themes and trends and taking action to reduce the risk to people in future.

● Systems were not embedded for the staff team to act on lessons learnt. For example, the large clinical waste bin had a broken lock. The bin was replaced, however when we returned, we observed staff not locking the new bin despite it now having a functioning lock. This meant clinical waste was easily accessible and increased people's risk of infection.

Preventing and controlling infection

● Known pest infestations were not treated quickly. We found one person's bedroom to be infested with bedbugs. The provider was aware of the infestation, however, had failed to take action to treat the parasites by referring to appropriate agencies, or provide alternative sleeping accommodation for the person.

● The provider failed to ensure effective infection prevention and control measures were in place. Cleaning procedures within the home did not ensure a clean and hygienic environment for people. We observed dust, debris, ingrained dirt, mould, stains and unsecured clinical waste during a tour of the premises. There were no designated cleaners employed at the home. The registered manager advised current staff members completed the cleaning.

● Rotas demonstrated staff members were allocated to multiple tasks at the same time. For example, one staff member was responsible for delivering care and responsible for completing the afternoon cleaning of the building at the same time. This meant cleaning tasks were not completed.
● Personal protective equipment (PPE) use was poor. We observed multiple members of staff including the management team not wearing a mask or not wearing it correctly. One staff member who suffered with breathing issues felt they were exempt from wearing masks; however, no guidance had been put in place to support this staff member. We have also signposted the provider to resources to develop their approach.

Medicines were not managed safely; IPC measures were not effective and there was a lack of risk management. This failure to keep people safe from harm is a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Visiting in care homes
The provider was following government guidelines in respect of visiting in care homes at the time of this inspection. There were no restrictions on people having visitors.

Staffing and recruitment
● There were not enough staff deployed to meet people's individual needs and keep them safe from harm. We observed people who required higher levels of support to be left alone on multiple occasions. We observed one incident where a person became distressed as another person had been shouting at them. The person who was experiencing distress should have been supported by two staff members at the time of the incident, however they were alone which meant the incident was not diffused promptly. This meant the person experienced distress due to the failure of staff not providing the correct level of support.
● We reviewed staff rotas. Staff were scheduled to be completing multiple tasks at the same time. For example, one rota described how a staff member was responsible for providing 1:1 care for two different people at the same time. 1:1 care means that one staff member should be providing care to only one person for a set period of time. This impacted on the care and attention that people received.
● Staff rotas showed one person who required 2:1 care had only been allocated one staff member. 2:1 care means that two staff members are required to provide care to one person for a set period of time. People who require 2:1 care often have more complex needs and can present a risk to either themselves or others. This meant the person was at risk of harm because they did not have the correct number of staff to support them.

Failing to provide sufficient numbers of staff in order to meet the needs of people using the service and keep them safe at all times is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. The four staff files we reviewed contained all of the information required by law. The provider was following their own recruitment policy and process.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

● Mental capacity assessments had not always been undertaken when required. Those that were in place lacked detail of which decision people lacked capacity for. This meant the provider had failed to work within the principles of the MCA. For example, records identified a person who had a dementia diagnosis. Capacity assessments should have been completed to assess which decisions the person had capacity to make, and if there were any decisions that required a best interest decision. No capacity assessments had been completed. This meant it was difficult for staff to ensure they had consent or were acting in the person's best interests to provide the appropriate level of support to this person.
● People's consent to care and treatment was not obtained in line with legislation and guidance. For example, records described how a person had been refusing their medicines. Mental capacity assessments had not been completed. This meant it was not clear whether the person had capacity to decline their medicines.
● Restraint was not always recognised by staff members or management. For example, we observed one person to have restrictions on certain belongings, have their medicine administration overseen, and their personal care supervised. It was not clear whether the person could consent to these restrictions or not. This demonstrated that care was not always provided in the least restrictive way.

● Deprivation of Liberty Safeguards conditions were not always adhered to. One person had four conditions attached to the DoLS authorisation. The provider had failed to meet all of the conditions, despite this being raised in two different formats by the DoLS assessor.

The failure to work within the principles of the Mental Capacity Act 2005 and associated code of practice is a breach of Regulation 11 Need for Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Staff members did not always receive specific training to support them in their role. For example, some people living at the service could hit out at staff members when they felt upset or emotionally distressed. Not all staff members had received training to help them support the person through this period of distress or keep themselves and other colleagues safe.

● We looked at records to ensure staff members were receiving regular competency checks. One person had a competency check in their folder; however, all the competency checks had been completed on one day and did not describe in detail what element of competency had been assessed under each section. This meant we could not be assured that staff members competency had been fully assessed by this recording process.

● We requested the provider's training matrix on the first day of inspection. However, the care manager advised the matrix was not up to date, nor reflective of staff's current training and expired training. This meant the provider could not provide assurances that staff were suitably skilled to complete their roles.

● The registered manager advised staff completed induction training before starting, and staff confirmed this. however, this training appeared to be ineffective as staff were unable to demonstrate competence in numerous areas such as person-centred care, safeguarding, and fire safety.

The failure to provide staff which are suitably qualified and competent is a breach of Regulation 18 Staffing of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The physical environment was in poor condition, and decoration and furnishings were dilapidated and unclean. There were cracks in the plaster on walls, stains and marks on furnishings and flooring, and paintwork which was heavily chipped.

● Bedrooms were in a state of disrepair. We observed peeling paint on the walls, worn carpets, stained and worn mattresses, broken blinds, and windows that would not stay open. We also observed that people's bedrooms were impersonal. The provider failed to consult with people about how they would like their bedrooms decorating.

● The garden space was unclean and unsafe. The garden contained a lot of rubbish and debris. The patio slabs were broken and lifting, creating a trip hazard. The garden path was very narrow, uneven and in poor repair meaning it was unsafe for people who could mobilise independently, and inaccessible to people using a wheelchair.

● The providers 'Premises Environment and Resource' maintenance policy stated that regular assessments of the premises, both internal and external, are undertaken and that any repairs or risks identified are dealt with promptly. Risk had not been identified, and repairs had not been actioned. This meant the provider failed to follow their own policy. This placed people at risk of harm or injury through the layout or design of the building.

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

● People were at risk of not getting enough to eat and drink. Diet care plans were in place; however, they were not always reflective of people's nutritional needs. For example, we reviewed one care plan which needed updating as there had been an improvement in the persons diet due to staff encouragement. Records showed there were inconsistencies between the food groups the person enjoyed in the care plan and the food groups the person was recorded eating in the daily records. This meant that new staff would not have the most up to date list of food groups the person enjoyed eating.
● The main dining room where most people ate their meals was not clean and was in a state of disrepair. We saw cracks in the plaster on the wall, the carpet was stained and a bin containing used PPE had a broken lid exposing the contents. This meant that people did not have a hygienic place to eat their meals.
● People told us they enjoyed their meals. One person told us, "The food is nice, I get a choice of what to eat." We observed people being given choices at lunch time and offered snacks and drinks throughout the day.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not always fully assessed. Assessments lacked detail which impacted on staff providing person centred care. For example, one person's assessment identified they can display behaviours that challenge, however there was no guidance for staff to offer support to keep the person, others and themselves safe. This meant the person may receive care in a way that did not meet their needs.
● Care and support was not always delivered in line with national standards or the law. For example, the provider failed to ensure a DoLS referral was submitted in a timely manner for a person who had moved into the service. This is not in line with the Mental Capacity Act 2005.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People did not always receive timely medical attention when issues had been identified. For example, we observed records demonstrating a person had made staff aware they were suffering with feelings of low mood and suicidal thoughts. However, staff had not referred the person to their GP, or sought any mental health support for them. This meant the person was at risk of their mental wellbeing deteriorating further, due to the lack of access to support services.
●Staff did not always contact other agencies proactively. For example, one person's wheelchair was in very poor condition. Despite staff supporting the person to use their wheelchair daily, staff had failed to make a referral to the appropriate agency for the person to be issued with a replacement. The inspection identified the poor condition of the wheelchair, this was raised, and a referral was then made.

The failure to comprehensively assess people's needs and choices, and the failure to seek timely medical intervention for people is a breach of Regulation 9 Person – Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person told us they felt they could access healthcare services when required. They stated, "I can see a doctor when I want. I can always ask."

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

- People were not always well treated and supported in a way that met their individual needs. Observations showed staff lacked the ability to meet people's needs when they experienced emotional distress. We observed an incident where a person was distressed. Three members of staff were trying to deescalate the situation, however the staff members kept talking over each other and the incident became loud and chaotic. This approach did not support the person to become calmer in a timely manner.
- People's equality and diversity needs were not always well catered for. For example, in one of the lounges there were four people using the room at the time. The TV was on and was showing programmes in the native language of three of the people in the lounge. The fourth person did not speak this language, and was a wheelchair user, unable to self-propel themselves. They also had difficulty communicating their needs. This meant the person was unable to leave the lounge by themselves, or vocalise if they wished to leave.
- Feedback on how people were cared for was mixed. One relative felt staff were good and compassionate. However, another person told us they did not like living at the home as there was nothing to do, and their relative confirmed they were unhappy with the care their loved one was receiving.

Respecting and promoting people's privacy, dignity and independence

- People's privacy was not always respected. We observed that several people using the service required an enhanced level of supervision. Guidance for staff did not provide them with information on how to support people in the least restrictive way. For example, guidance did not describe what staff should do if the person wanted to go to the toilet or go for a nap. This meant that people were at risk of having a lack of privacy.
- People's dignity was not always respected. All communication with people using services must be respectful. Records described incidents where some staff spoke to a person in a disrespectful way. Records also demonstrated staff using inappropriate language to describe the person.
- People's independence was not always promoted. There was a lack of structure to people's day. Staff often controlled whether people participated in activities or went out to places of social interest. This meant it was difficult for people to make decisions independently as they were unsure what was happening next.

People did not receive care in a way that met their individual needs, promoted their independence or respected their equality and diversity. This is a breach of Regulation 9 Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We met with the provider following the inspection and took assurances they are working on improving person-centred care delivery.

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

● Relatives were not always consulted in relation to discussions about the care their loved ones received. For example, we reviewed records which described how a person's relative held a Lasting Power of Attorney. This meant they had the legal right to be involved in decisions about their relative's care. However, they told us they were not involved with decision making. Records we reviewed confirmed this.

● People did have a space to express their views. The registered manager told us they conduct meetings for all people who live at the service. We saw evidence that these meetings had taken place. People who could not easily express their views were supported by a staff member who spoke their native language. This meant people could raise issues and discuss any topics they wanted to comment on.

Inadequate

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 Inadequate.

This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People did not receive person-centred care that met their needs and individual preferences. For example, one person required dedicated 2:1 hours with staff members. During this time, there was minimal interaction between the staff members and the person. Staff interacted amongst themselves, however not always with the person they had been allocated to provide care to. Observations showed the person wanted to interact, as they were happy to interact with the inspectors on multiple occasions. They also showed signs of boredom, such as pacing and trying to engage with other people living at the service. Records demonstrated a lack of activities offered to this person throughout their day.
- People's emotional needs were not always taken into consideration. For example, we observed a large amount of furniture being moved during the inspection in an area where two people were relaxing. It became very chaotic and noisy with the furniture being dragged across the floor, and as a result, both people became distressed.
- Care plans did not demonstrate that people were able to choose who supported them and how they were supported. Care plans lacked detail about people's lives prior to admission, and relatives were not always involved to ensure people's preferences were recorded.

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.

- The provider failed to comply with the Accessible Information Standard. The majority of people living at the service did not speak English, however all signage around the home was in English. We observed one wall in the home which had been decorated with posters to educate people living at the service about different types of abuse. All the words were in English, and whilst pictures were on some of the posters, the posters were positioned in a slanted manner, making it difficult to read and disorientating. We did not see any easy read information available for people.
- Interactions with people demonstrated that one person preferred to be cared for in bed. We observed a senior carer plug in an extension cord to make it easier for the person to press the buzzer and communicate with staff. We were concerned this extension was only plugged in during our inspection, as it was plugged in

whilst the inspectors were in the room. When this was queried, the staff member advised they were plugging it in to make it easier for the person to reach the call bell. This meant the person had been negatively impacted previously in respect of communicating with staff.

● Relatives stated staff seemed to be mostly well trained, however advised training in communication would be beneficial and would make communication with their loved ones and themselves easier.

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

● The service failed to support people to maintain their hobbies and interests, and provide meaningful activities, or enrichment for people to participate in. Hobbies and interests had not been considered fully, and the provider did not make full use of the space available within the property to deliver different activities sessions.

● People were not always supported to engage with activities in the community. One person had additional hours of support each day for staff to take them to places of religious worship and social interest. Our observations showed this person to not receive all these additional hours each day. This impacted on the person as they were observed on three separate occasions to pull on the front door to go out. Records confirmed the person had not received all of their additional support hours.

● People were unable to go out and enjoy the garden of the home. Access was problematic, and the outdoor space was bland and uninviting. There was a collection of rubbish and debris, and the dustbins had been placed next to the table and chair set in the sitting area.

● One person used the garden to smoke cigarettes. The door was secured by a number keypad to prevent people leaving. We observed the person to become stuck in the garden on multiple occasions as there was no way for them to communicate with staff when they wished to re-enter the home. We raised this with the management team, who advised a doorbell would be installed. However, this was not actioned in a timely manner, meaning the person continued to be unable to communicate their needs to staff.

The failure to provide care which meets people's individual needs is a breach of Regulation 9 Person-Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported to keep in touch with loved ones. People communicated using the telephone or their iPad with family members. Inside the home, circles of friends were supported to spend time together.

Improving care quality in response to complaints or concerns

● People and relatives gave mixed feedback about complaints handling. One relative advised they had never had a reason to make a complaint but knew how to make a complaint if they needed to.

● However, another relative said they had raised the same issue multiple times and no resolution had been reached. This left them feeling frustrated and completing care tasks themself when they came to visit their relative. The provider did have a complaints policy, however feedback did not always evidence this had been followed and that all complaints had been dealt with satisfactorily.

End of life care and support

● At the time of the inspection, nobody living at the service was receiving end of life care and support. Advanced end of life care plans ranged in quality. We reviewed one which lacked detail and had not been completed in a timely way, however another one was tailored to the individual wishes of the person and detailed their religious wishes at the end of their life.

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

- The provider failed to ensure a culture which promoted person centred care. Outcomes for people did not reflect the principles and values of Right Support, Right Care, Right Culture. For example, people were not encouraged to have maximum choice and control over their support, and people did not receive planned and coordinated person-centred support that was appropriate and inclusive for them.
- The physical environment was poorly maintained, and there was little attempt to meet people's individual sensory needs. Lighting was very bright and there was little regard for people with noise sensitivity.
- Information on how people were progressing or struggling with interests, hobbies or daily living tasks was rarely recorded. Care plans needed reviewing, however only one person's care plan had been reviewed. This meant the management team did not have oversight of what was working well, or areas people needed additional support with.
- The registered manager told us they employed staff who spoke the mother tongue of all people at the service. The registered manager said, "We are very multicultural. We celebrate all cultures." Observations showed not everyone was supported in the most culturally appropriate way. For example, only one person at the service who described their native language as English spent a large amount of their day in the communal lounges, as opposed to their bedroom. Staff who could communicate in English did not spend additional time interacting with this person, to ensure the person did not become isolated as they were unable to communicate with other people living at the service.

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

- The provider failed to establish robust governance systems to oversee the quality and safety of the service. Current systems and processes did not ensure the provider was able to identify where quality and safety was being compromised and respond to it appropriately and without delay. For example, mental capacity assessments were not completed for people. Staff did not understand their legal requirements in respect of mental capacity or meet those requirements. This placed people at risk of receiving inappropriate or unsafe care.
- The registered manager failed to ensure audit and governance systems were effective. For example, we identified very few audits were being completed. Those that were completed were ineffective as they had

failed to identify issues we raised during the inspection. This was raised with the registered manager who advised audits would be conducted. However, when we returned, audits had not been completed.
● Records did not record reflective practice taking place. This meant the provider could not evidence that they learnt from incidents to improve care.
● Not all notifications were submitted to the commission. This is because incidents had not always been picked up by the staff team, or management team, and they therefore had not been reported upon. Incidents that had been identified, had statutory notifications completed and submitted.
● Systems and processes did not ensure behaviour support plans clearly described how additional staff support should be deployed, or how it benefited the person. The lack of oversight from the registered manager and management team meant records lacked guidance for staff on how to provide support in the least restrictive way. Behaviour records demonstrated staff used inappropriate language to describe people and their behaviour. This had not been identified prior to inspection as the behaviour records had not been audited.

Continuous learning and improving care
● Concerns were not dealt with in a timely way. Records described how a person was being left in significant distress as staff were unable to meet their primary needs for food, drink and personal care. This was raised with the nominated individual on 9 August 2022. When we returned on 30 August 2022, records described how the person was still experiencing the same levels of distress as staff were still unable to identify the person's needs.
● Systems and processes did not assess, monitor and mitigate risks to people posed by unsanitary sleeping conditions. During mattress checks, we identified one mattress in particular which was in extremely poor condition. Staff members advised the mattress would be changed without delay. We checked again later, and the mattress had not been changed. We raised the issue again, and the mattress was then replaced for a new one, which was already onsite. The provider was unable to justify the delay in replacing the mattress.

Working in partnership with others
● Systems and processes did not support the collaboration with external stakeholders and other services. For example, a person living at the service was under a DoLS order. These set out certain conditions which the provider must adhere to. The provider had failed to meet all of the conditions set out in the persons DoLS, despite this being raised in two different formats by the DoLS assessor.
● The provider failed to work in partnership with other services. We observed one person return from an external day centre feeling extremely thirsty. This was demonstrated by the person's behaviour. Staff did not have any information on how much the person had drank at the day centre, or if there had been any concerns in relation to fluid intake during their time away from the home. Staff were not timely in seeking this information from the day centre. This lack of partnership working means vital information pertaining to the care of people was not obtained.

The provider failed to ensure systems and processes monitored and improved the quality and safety of the service. This is a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● Throughout the inspection, the registered manager was open and transparent with inspectors. The registered manager was aware there were issues within the home and welcomed feedback from the inspection.

● However, whilst the registered manager understood their role in relation to duty of candour, this was not always acted upon. This is because some safeguarding issues had not been identified prior to the inspection, and therefore had not been reported. We also found there was sometimes a delay in the management team putting things right which were raised as part of the inspection. For example, the doorbell on the back door into the garden, and the person experiencing significant distress.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to provide care which met people's individual needs.

The enforcement action we took:

We sent the provider a warning notice. This gives the provider a period of time to make to required improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to complete all required capacity assessments, and work within the principles of the Mental Capacity Act 2005.

The enforcement action we took:

We sent the provider a warning notice. This gives the provider a period of time to make to required improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care and treatment.

The enforcement action we took:

We sent the provider a warning notice. This gives the provider a period of time to make to required improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the risk of harm and abuse.

The enforcement action we took:

We sent the provider a warning notice. This gives the provider a period of time to make to required

improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have adequate oversight of the service to ensure the delivery of safe and person-centred care.

The enforcement action we took:

We sent the provider a warning notice. This gives the provider a period of time to make to required improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough numbers of staff deployed to meet people's individual needs.

The enforcement action we took:

We sent the provider a warning notice. This gives the provider a period of time to make to required improvements.