Mitchell's Care Homes Limited

Nutbush Cottage

Inspection report

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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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Nutbush Cottage provides accommodation and personal care for up to 4 people who have a learning disability and/or autistic people. At the time of our inspection, there were 4 people living at the service.

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

Right Support: People were not always given the opportunity to go out and do things they enjoyed. People's wishes and needs were not put at the centre of the service and their aspirations were not identified and supported. 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. People were not always protected from the use of unlawful restraint and the lack of robust auditing meant that people were not always protected from the risk of financial abuse.

People's anxiety and distress was not responded to in a consistent way and additional support from professionals was not always sought in a timely way. People's communication needs were not known to staff, and professional guidance was not followed. This meant people had limited choices and opportunities to express their views.

Medicines were not managed safely which meant people were at risk of not receiving their medicines in line with their prescriptions. The hours staff worked were not effectively monitored which resulted in people being supported by staff who had worked day and night shifts without sleep or breaks away from the service.

Right Care: People's dignity and privacy were not always respected. Staff stood over people and did not always communicate in a caring way. There was no lock on the main bathroom door and one person had been without curtains or window coverings in their bedroom for several months.

People's health needs were not always monitored and there were delays in health referrals being made for some people. People were not supported to develop their independence. With the exception of one person, people were not encouraged to be fully involved with maintaining their home, preparing food or doing their own personal shopping.

Right Culture: The culture at Nutbush Cottage did not support people living fulfilled and empowered lives.

Staff were unable to demonstrate their understanding of 'Right support, right care, right culture' guidance and how this should influence the support people received. The views of people and staff were not sought to ensure they could contribute to the running of the service.

There was a lack of management oversight which had led to concerns not being identified and acted upon. Audits and reviews were not effective in identifying shortfalls in the care and support people received. People's quality of life was not central to audits and action plans. The provider had not ensured additional support was in place given the previous manager was new to their role and was not registered with the Care Quality Commission. Systems in place did not drive high standards and ensure continuous development.

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 21 November 2019)

Why we inspected
The inspection was prompted due to concerns received about people not being protected from the risk of abuse, concerns around safe staff levels and lack of robust management oversight. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to people being at risk of abuse, safe care and treatment and staff deployment and skills. We have also found people's care was not person-centred, people were not always treated in a caring way, people were not supported to do things they enjoyed and there was a lack of management oversight at this inspection.

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

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

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?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not 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.

Nutbush Cottage

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 2 inspectors.

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

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

At the time of our inspection there was not a registered manager in post. At the time of our inspection a new manager was in post who had been based at the service for just over two weeks. They told us they intended to register with Care Quality Commission. Following the inspection, the provider made the decision to make changes to the management structure. This resulted in the previous manager returning to Nutbush Cottage.

Notice of inspection
This inspection was unannounced.

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 and professionals 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 observed people and their interactions with staff and each other throughout the inspection visits. We spoke with 1 person, 2 relatives/representatives and 2 health and social care professionals to gain their views. We also spoke with 7 members of staff including 5 care staff, the manager and previous manager. We viewed a range of records held within the service, this included 4 care plans and medicines records. We looked at 3 staff files in relation to recruitment. A variety of records relating to the management and oversight of the service, including staff training records, risk assessments, policies and procedures were reviewed. After the inspection we continued to receive information relating to quality assurance audits, policies and procedures. We sought clarification on staffing, staff training and competencies.

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 always protected from the use of unauthorised restraint. One person's daily records contained numerous reports from staff stating they prevented the person from leaving their bedroom during the night. They referred to the person showing signs of high anxiety and being further distressed by being prevented from leaving their bedroom. The persons care plan did not refer to this practice and there was no risk assessment or best interest decision in place. Approval for this practice had not been sought from the local authority as part of the persons Deprivation of Liberties Safeguarding authorisation. We spoke with the persons representative who confirmed the provider had not informed them the person was being restricted from leaving their room.
- During our inspection we also observed staff blocking the entrance of a person's door as a deterrent to them leaving the room when they were anxious. There was nothing recorded in the person's care plan to indicate this practice had been approved by the local authority.
- People were not always protected from the risk of financial abuse. Financial records for one person who owned their own car did not contain evidence of the mileage completed. It was therefore not possible to cross reference mileage against the amount of fuel the person had paid for. We raised this concern with the provider who assured us they would maintain mileage records going forward.
- Not all staff were aware of how to report safeguarding concerns. Staff we spoke with told us they would report any concerns to their manager or to the office. However, 3 of the 5 staff we spoke with were not aware they could contact the local authority safeguarding team directly should they feel the need to do so.

The failure to ensure robust systems were in place to protect people from the risk of abuse was breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people's safety and well-being were not always reviewed to ensure they were getting the support they required. One person's records showed they had experienced prolonged periods of distress and anxiety resulting in them not sleeping. This had also disturbed others living at Nutbush Cottage. The previous manager told us this was due to the person experiencing a significant loss. Despite this knowledge no steps had been taken to explore how staff could best support the person during this time to provide comfort, understanding of what had happened or to minimise risks to the person or others.
- People's care records lacked details regarding the support they needed when anxious or distressed. Triggers and initial indicators that people were upset were recorded and known to staff although guidance on how to support people was not always specific. One person was known to be distressed by people they did not know visiting their home. During the inspection the person was showing clear signs of anxiety due to our presence. Staff did not demonstrate a consistent approach to providing reassurance to the person

during this time. Although this was a regular cause of the persons anxiety, there was no specific guidance for staff to follow in relation to this.

● Incident reports or monitoring systems were not used to track people's anxiety and review support. There were no established systems in place to collate information so this could be analysed and shared with other professionals when required. This meant the provider was unable to easily identify any themes or trends to minimise concerns happening again and to seek the right support for people.

● Positive behaviour support plans did not demonstrate a good understanding of people's needs and were not consistently followed. One person's plan contained wording such as, 'If I am refusing to calm down' and, 'remove me to a quieter environment'. This indicated the person was in control of their anxiety rather than in need of support. There was no guidance given as to how staff should 'remove' the person. The plan also recommended keeping the person busy and re-directing them to their planned activity. We observed that whilst staff periodically offered reassurance when the person was anxious, they did not offer them anything to do.

● Routine health checks were not always completed by staff to minimise risks. We asked the manager how people's oral health care was monitored. They told us staff should complete checks when supporting people to brush their teeth. One person's care notes stated they had been supported to visit the GP due to them not eating. The GP had identified the person had a loose tooth which had led to them having a number of ulcers which required treatment. There was no record of staff checking the person's oral health.

The failure to ensure robust safety and risk management systems was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The views of staffing levels from people and their representatives varied. Comments included, "They always seem to have staff around." A second comment reflected a person would like to go out more, but staff were busy. This was despite the person receiving funding for the 1-1 support they required to go out.

● Sufficient staff were not always available to support people's needs. Staff and professionals involved in people's care informed us 2 people living at Nutbush Cottage were funded to have 1 to 1 support, 24 hours per day. Records showed that these levels were not consistently sustained. Rosters showed that only 2 staff worked on night shifts providing support for all 4 people. This meant people assessed as requiring 1 to 1 support did not consistently have access to this during the night.

● The manager informed us that as 1 person went to visit their family at weekends only 2 staff were required. The person's care records showed they did not leave until after lunch on Saturday and returned in the early evening on Sunday. This meant staff numbers had been reduced when it was not safe to do so.

● People's safe care was at risk due to the number of consecutive hours staff worked. Staff timesheets showed staff had worked consecutive day and night shifts during December, March and April 2023. We identified numerous occasions when staff had worked for 48 hours without a planned break. On one occasion a staff member had worked for 96 hours with only one 11-hour break between shifts.

● Due to the long hours worked staff acknowledged they needed to sleep whilst on waking night duty. A waking night shift is when staff are required to remain awake throughout. One staff member told us, "I can't say I don't sleep when things are quiet. There is no agreement about this as such, it's just an assumption that we would need to have some rest. There was no risk assessment in relation to the long hours staff worked or in relation to them sleeping whilst on duty.

The failure to ensure sufficient staff were available in line with people's needs and that the hours staff worked did not present risks to people was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Robust recruitment checks were not always completed. The provider recruitment policy stated they should obtain 2 references for all staff, 1 being from their last employer. Recruitment records showed no references had been obtained for 1 staff member. A second staff member had a reference from an employer not listed on their application form or CV and 1 personal reference. No reference had been obtained from their previous employment in the care sector. This meant the provider was not able to assure themselves all staff employed were suitable to work at Nutbush Cottage.

The failure to ensure safe recruitment checks were completed was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Robust medicines processes were not consistently followed to ensure people received their medicines in line with their prescriptions. One person was prescribed an anti-psychotic medicine to be taken as and when required (PRN) during times of high anxiety. During our inspection we found a number of these tablets were unaccounted for and requested the provider investigate this concern. They informed us that the person had also been prescribed the same medicines on a regular basis for a month during February. However, there was no record of this medicine being administered during this time and no record of it being disposed of. This increased the number of tablets unaccounted for and meant the person may not have received their medicines in line with their prescription.

● Staff did not follow recording guidance for PRN medicines. During the inspection the manager informed us staff had administered PRN medicines to 1 person. There was no record of this within the persons medicines records. This meant there was a risk other staff would administer additional doses of the medicines. We observed the manager showing staff how PRN medicines should be recorded despite the staff member having previously been signed off as competent in medicines management.

● Prescribed PRN medicines were not always available or accounted for. A further 2 people were prescribed PRN medicines to support them during times of anxiety and PRN guidance was in place. However, the medicines were not in stock and there was no record as to when these had last been available to people. The manager told us they had identified the medicines were not in stock and requested the prescriptions. There was no record of either medicine being administered in 2023 or record of the medicines being returned. This meant there was a risk people may not receive these medicines if required and the provider was unable to assure themselves the medicines had been accounted for.

● Accurate medicines records were not maintained. Medicines were not signed into the home on the medicines administration record. This meant staff were unable to complete accurate stock checks in order to monitor if people had received their medicines as required.

The failure to ensure robust medicines management systems were in place was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some areas of the home were not cleaned to a good standard. The downstairs shower room had signs of mould and a number of the windows and doors were dirty.

The failure to ensure high standards of hygiene and infection prevention and control was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of

infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● 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.
● People were able to receive visitors to their home in line with government guidance.

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.

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

- Best practice guidance was not always followed or understood. Staff were unaware of the content or scope of the Right Support, Right Care, Right Culture guidance. Staff were unable to describe what this guidance was about or how it should impact on the support they provided. During our inspection we found the principles of Right Support, Right Care, Right Culture were not followed, and people were not empowered to live as ordinary life as possible in line with this guidance.

The failure to ensure best practice guidance was followed was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The needs of people moving into Nutbush Cottage were assessed. Assessments reviewed details of people's needs and life history prior to moving into the service to establish if they could be met. One relative/representative told us they felt the assessment had been completed well.

Staff support: induction, training, skills and experience

- Staff training was not effective in ensuring staff had the skills required to support people effectively. Staff spoken with had completed training in supporting people with a learning disability and autism. However, they were not able to describe how this had impacted on their practice or describe the content of the training. One staff member told us, "We do all the training online and there were so many in one day. There are so many courses I cannot remember all that we did."
- Staff competence and knowledge was not effectively monitored. Staff did not understand the importance of visual aids or commonly used communication systems. This meant people were not supported with their communication needs effectively. Despite completing competency assessments in medicines management, we found staff lacked knowledge in both administration and recording.
- Staff did not receive regular or effective supervision to support and guide them in their roles. Supervision records for January 2023 were identical for 9 staff members. These gave directions from the previous manager regarding tasks to be completed. There was no individual discussion in relation to the staff member's performance, training needs, concerns they may have or individual goals and development.

The failure to provide effective training, induction and supervision to all staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The service lacked personalisation and did not feel homely. The lounge and dining areas were sparsely furnished with few items to create a comfortable feel. Whilst some people had been supported to personalise their rooms others did not reflect people's personal choice.
● There was no office area within the service. Staff completed administrative work in the dining room which caused upset to some people living at Nutbush Cottage. The medicines cabinet and a lockable cabinet containing confidential files were in the dining area. We observed staff working on the dining table with their laptops and the inspection team were advised to use this area to work. Two people were visibly upset by this and repeatedly tried to move the equipment or files. The manager told us when they were there they tried to be as discreet as they could so as not to upset people. However, using communal spaces for staff administrative work was clearly having an impact on people. Following the inspection, the nominated individual told us they had taken action to relocate the medicines cabinet and provided a lockable desk so staff do not have to work from people's dining table.

The failure to show respect for people's home was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People did not always receive the support they required to meet their health care needs. One person's records showed during a health review the previous manager had informed the GP they had referred the person to the Community Learning Disability Team in October 2022 due to their high anxiety levels. However, no referral had been received by the team and there was no evidence of this being completed or sent. This meant there was a delay in the person receiving the support they required.
● Health appointments were not monitored or tracked. We were informed people had health action plans in place detailing their health care needs. However, these were not recorded on the support planning system or within people's individual files. This meant staff did not have access to detailed guidance regarding people's health care needs.
● There was a lack of detail when recording consultations with health care professionals. Records did not always state why people were seeing professionals and the outcome of visits were not recorded clearly to ensure any advice provided was followed.
● Professionals we spoke with told us it could be difficult to obtain information from the service. One professional said they had needed to ask for information several times. They stated they did not feel there was always an open and transparent approach to discussing people's support.

The failure to ensure people's health needs were robustly monitored was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 were not always aware of people's legal rights. As referred to within the safe area of this report, records showed one person's movements at night were being restricted. There was no capacity assessment or best interest decision to confirm this was the least restrictive way to support the person. This practice had not been shared with the persons representative and was not recorded on the DoLS application or authorisation. Following our inspection, we made the local authority and the person's representative aware of these concerns.
● In other areas we found relevant capacity assessments were in place and best interest decisions were completed. These covered areas including people living in a secure environment, one to one support and consent to care.
● DoLS application had been submitted as required. Conditions in place were in relation to dates for reapplication which were all noted to be completed in a timely way.

Supporting people to eat and drink enough to maintain a balanced diet
● As reported in the Caring area of this report people did not always have a choice regarding their food and people did not have access to menu plans.
● We observed one person was able to make their snacks independently and had a choice regarding this. The person told us they enjoyed the food staff prepared and they felt they could say if they didn't like something.
● People received the support they required at mealtimes. Staff sat with one person who needed guidance regarding eating their food more slowly. Staff spoke with the person in a kind way and provided gentle encouragement.

Inadequate

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 inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- Staff did not see people living at Nutbush as their equals. Whilst staff showed kindness to people in their manner there was an atmosphere of staff being in charge rather than being in people's home. For example, when administering medicines this was done in the dining area rather than in private. The staff member dispensed people's medicines and placed them on the table with water. They then asked other staff to alert the person who was then assisted to the dining area, asked to sit down and take their medicines whilst staff stood over them with their arms crossed and observed. The person was then told they could leave the table. This appeared highly undignified and signalled a controlling manner from staff.
- Staff did not consider the language they used when speaking to and about people. Terms used by staff both verbally and in care records included terms such as 'home leave' and 'absconding'. This showed a lack of acknowledgment from staff that Nutbush Cottage was people's home. The language used by staff to describe people experiencing high anxiety demonstrated a lack of understanding and empathy. One person was described by staff in a highly distressed state as being like a person 'possessed'.
- People's privacy was not always respected. One person told us they worried when in the bathroom as there was no lock on the bathroom door and a second person would try to come in. We observed the person trying to go into the occupied bathroom during our inspection. The manager told us the lock had been removed as staff had been unable to enter when someone had flooded the bathroom. No consideration had been given to fitting a lock which could be opened by staff from the outside in case of an emergency. The person also told us the second person would enter their bedroom uninvited. There was no reference to this in either person's care plan to guide staff in how to respond to this.
- There was a lack of dignity being shown to people. One person did not have any curtains or a covering at their bedroom window. Staff were unable to say how long this had been the case. The manager told us these were on order. On the second day of inspection the manager said a large delivery had been received in the office that day, so they were hoping this included curtains for the person. However, three weeks after the first inspection date the previous manager confirmed the person was still without curtains.
- The environment was not personalised and did not look comfortable or homely. This included people's bedrooms which were sparse and lacking in personalised items. There was no 'office' space which meant the medicines cabinet and some records were stored in people's dining room.
- Staff did not always support people in a respectful manner. On the first day of our inspection 1 person was anxious about our presence. A staff member stood 'guarding' the persons door for a number of hours. The bedroom door was open with the staff member blocking the entrance. Whilst the person could, and on occasion did, push past the staff member, this was undignified for the person. There was very little

interaction between the person and the staff member during this time.

The failure to ensure people were treated with dignity and their privacy respected was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People and their relatives/representatives told us they felt staff listened to their views. One person told us, "They're always giving me choice."
- Despite these comments we found not everyone living at Nutbush Cottage received support to express their views and make choices. Not everyone was offered choices in relation to what they would like to eat, drink or how they wanted to spend their time. At mealtimes food was prepared from the menu and without consultation regarding if this was what people wanted. Staff told us, "We follow the menu for shopping and meals."
- Not everyone living at Nutbush Cottage was able to verbalise what they wished to do. When people were offered the opportunity to go out, the decision as to where to go came from staff rather than offering people different option. No visual aids, photographs or communication systems were used in order to fully involve people in decisions regarding what they wished to do.
- Residents meetings were held to discuss the running of the home. Minutes showed that people were asked questions verbally such as if they had any complaints or if they felt safe. Their vocal responses were then recorded. There was no evidence to demonstrate how people had been supported to understand the question and people's responses were not interpreted. For example, one person responded to the questions by using words including 'coat on', 'mini-bus mini-bus', and 'Go go out'. There was no acknowledgment or exploration as to when, where or what the person wanted to do from their responses.

The failure to ensure people were involved in decisions about their care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; 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 to go out and do things they enjoyed. Care notes for a 3-month period between December 2022 and February 2023 showed that with the exception of visiting their family 1 person had only been out on three occasions. A second person had only been supported to go out on 9 occasions over the same 3-month period. There was nothing within either person care notes to indicate they had declined the opportunity to go out.
- People's 'Activity' plans were not available to them to support them in making choices. We asked 1 staff member if we could view people's 'Activity' plans as these were referred to within people's care plans. They told us they were on the house laptop, so they were unable to access them. A second staff member and the manager told us these used to be printed but since the service went paperless this was no longer the case. This meant consideration had not been given to how people could view their own plans for their time.
- Despite people's plans highlighting a range of different things people enjoyed doing, such as going to the pub, out for lunch, to the cinema and using day care activities we found these were not followed. The majority of the time people went out this was for a local walk or a drive with no specific destination.
- People were not supported to develop their interests when at home. Daily records showed people were reliant on the use of their electronic tablets and the television when spending time at home. One person's support plan contained a report from health care professionals recommending staff continued to support the person to develop a balance between the use of their electronic tablet and other activities. This was based on the person using their electronic tablet for 20 minutes in each hour. Staff did not know of this recommendation and told us the person had their electronic tablet for the whole day. We observed this to be the case during our inspection.
- People were not supported to set goals and review their achievements. We asked staff to show us what goals people were working towards. Staff told us they were not aware of any specific goals for people and records confirmed this was the case. The manager told us they were aware this was a potential area of development for the service.
- Daily living tasks were in the main completed by staff with little involvement from people. Staff told us the majority of people had some involvement in their laundry, but staff completed all other tasks including cleaning and cooking. This meant people were not being supported to develop skills and gain independence in some areas of their lives.
- Staff frequently completed people's personal shopping without their involvement. Receipts for toiletries showed most people's personal items were bought in the same shop at the same time. Staff confirmed that on some occasions one particular person may go shopping with staff the majority of the time this was done for people. This took the opportunity to make choices and gain understanding away from people.

The failure to ensure people's needs and wishes were met and the lack opportunities to go out and do things people enjoyed was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. 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.

● People's communication needs were not known to staff. One person had a support plan from the Speech and Language Team. This gave guidance to staff on the use of pictorial prompts and how to use the system to prepare the person from transitioning form one activity to the next. We asked two staff members how this system worked. They told us they had not heard of the system and had not known pictorial prompts could be used to support the persons communication. We did not observe this communication system being used with the person during our inspection.
● People's sensory needs were not taken into account. One person had significant sight loss. There was limited information in relation to this with no information for staff regarding what this meant to the person, how it impacted on communication or how staff should approach them.
● Systems and guidance to support people to communicate their needs and wishes were not in place. One person's support plan reflected the vocal sounds they may make but did not indicate always indicate what these meant to the person or how staff should respond. The support plan further stated staff should use short sentences when 'instructing' the person. Staff told us, "(Person) understands what you say to them." This demonstrated a lack of understanding that the person should have support to communicate their wishes to staff.

The failure to ensure people's communication needs were met and recommendations followed was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● People and their relatives/representatives told us they would be able to raise concerns with the manager and felt they would be addressed. One relative/representative told us, "I can talk to the manager and I think they'd work with us."
● The provider had a complaints policy in place. This set out details of how concerns could be raised, timescales for receiving a response and how they would be investigated.
● The manager told us they had not received complaints from people or their relatives/representatives within the last 12 months.

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

- People and relatives/representatives told us they felt the management team and staff were approachable and understanding. One relative/representative told us, "I have no problem with the staff at Nutbush and we can talk to them if we need to."
- Despite these comments we found people's needs and wishes were not put at the heart of the service people received. The provider had not ensured people received the support they required to live full and empowered lives. Whilst we observed some positive individual interactions with people, staff did not approach people as their equals.
- There was a lack of management oversight which meant people's quality of life at Nutbush cottage was not reviewed. Management responses to concerns raised demonstrated they were not aware of how the service was run. For example, when discussing the lack of opportunities for people to go out, a senior manager told us this was not the case, and that people regularly had the opportunity to do a range of things they enjoyed. However, daily notes did not show this was the case and the management team were unable to provide any specific evidence when requested.
- The provider had not ensured the previous manager received the support they required in their role. The provider told us the previous manager had been new to the role and they had not fully understood their responsibilities. Despite this, the provider had not completed any additional checks during this time. The provider had not recognised the importance of providing additional oversight as neither the previous nor current manager had been registered with the Care Quality Commission.
- Audits were not effective in identifying concerns with the care and support people received. Three audits had taken place during 2023. The first audit reviewed leadership tasks and the remaining 2 focused on safety. These had failed to identify concerns in relation to the risks including risks to people's safety due to their anxiety levels, medicines concerns or the lack of cleanliness in some areas of the service. Audits completed were mainly records based and did not take into account people's experience of the support they received.
- The service did not have a culture of continuous learning and improvement. The action plan for the service did not include any goals or aspirations regarding how to develop the service. The main actions highlighted were for staff to read and sign policies although no guidance was given as to why this was important or how staff understanding should be tested.
- There was a lack of leadership and guidance regarding the number of consecutive hours staff were working. Although staff timesheets clearly showed the number of hours staff were working, staffing concerns

had not been reviewed. Although timesheets clearly showed the number of consecutive hours staff were working this practice had not been stopped. Supervision records from January 2023 showed staff had been informed they would no longer be able to work over 60 hours per week. However, timesheets from March and April 2023 demonstrated staff continued to be asked to work excessive hours.

● Concerns raised were not investigated in an open and detailed manner. We requested additional information regarding 1 person's medicines errors. This information was requested on 3 occasions before it was received. The investigation report had not included a review of the correct timeframe and had not reviewed people's records. This meant the conclusions reached were incorrect and had not identified additional concerns.

● The provider had not ensured robust financial monitoring. As reflected within the Safe area of the report, audits had not identified the lack of mileage recording for one person's car to ensure petrol costs were accurate.

The failure to embed a positive and inclusive culture and to ensure robust management oversight was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People did not receive effective support to express their views on how the service was run. People did not have access to information such as menu plans, activity plans or resident meeting minutes. The manager and staff told us these used to be printed out but since the service went paperless, they were now all stored on the computer. Consideration had not been given on how people would be able to access these.

● Residents meeting minutes did not demonstrate how people's opinions were taken into account of what different communication methods had been used to gain people's views. For example, minutes stated people were asked if they had comments about the food. However, no pictures were used to discuss food options and no pictorial menu plan was available.

● Staff were not given the opportunity to contribute to the management of the service in a meaningful way. Staff meetings were repetitive and did not discuss people's needs, plans or issues. Each item on the minutes began was a direction from the previous manager with no input from staff reflected. This did not encourage a culture of open discussion where staff were able to share ideas and good practice. Minutes from the February and March 2023 staff meetings were virtually identical.

● People were not encouraged to develop links in their local area. The previous manager told us that prior to COVID-19 people had been more active in the local area as they took part in more activities. However, this did not take into account that restrictions had not been in place for a significant length of time.

● Information shared with professionals was not always open and transparent. Professionals involved in people's care were not always aware of people's limited opportunities to do things they enjoyed or their levels of anxiety. Review reports did not give a detailed view of people's involvement in their care. This meant professionals were unable to accurately monitor people's well-being and quality of life to ensure they received the support they required.

The failure to ensure views of people, relatives/representatives, staff and professionals were acted upon was a breach of 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a duty of candour policy in place. They told us there had been no incidents which had reached this threshold. Relatives told us they were informed of accidents and incidents involving their loved ones.