Care @ Rainbow's End Limited

Care @ Rainbow's End

Inspection report

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25 May 2023

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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.

About the service
Care @ Rainbow's End is a residential care home providing personal care for up to 5 people with a learning disability. Accommodation is provided over two floors. A communal lounge, and Kitchen with a dining room are based on the ground floor. At the time of our inspection there were 5 people using the service.

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

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.

Mental capacity assessment had not been carried out robustly by the provider to ensure people were supported to have maximum control of their lives and supported in best interest safely; the policies and systems in the service did not support this practice.

The provider did not have effective processes or systems in place to safeguard people. to ensure they were safe from harm. Staff did not understand when a safeguarding needed to be reported to appropriate bodies.

People were not supported by staff who had been appropriately trained and were competent. People had not received their medicines safely.

Right care
People's care plans and risk assessments did not cover their range of care and support needs. Staff were not guided to support people in line with legislation, good practice and their training. People had not been protected from harm and abuse.

The provider had not always provided staff with information and guidance to support people who were expressing distress and emotional distressed to ensure people had positive outcomes. Individual risks were not always assessed or managed well, and this placed people at risk.

Right culture

The service was not well-led. There was no effective governance system in place to monitor the quality of the service provided to people. The provider continued to fail to recognise risks and concerns in relation to health and safety, safeguarding, completing records and medicine management.

The provider continued to not follow recruitment legislation and ensure staff deployed had the right employment checks and skills to support people safely.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 9 December 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out our previous unannounced focused inspection of this service on 7 November 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, need for consent, and governance. We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions of safe, effective, and well-led which contain those requirements.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvements 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, and well led sections of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Care @ Rainbow's End on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to providing safe care and treatment, medicines management, infection control, safeguarding, consent to care, and management of the service at this inspection.
We took enforcement action 19 May 2023 and imposed conditions to the registration.

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 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.

The overall rating for this service is 'Inadequate' and the service is 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 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 safe findings below.

Is the service well-led?

Inadequate

The service was not well-led .

Details are in our safe findings below.

Care @ Rainbow's End

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

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Care @ Rainbow's End 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. Care @ Rainbow's End 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 a registered manager in post. For the purposes of the report, we refer to the provider who is also the registered manager.

Notice of inspection
This inspection was unannounced on 16 May 2023; we returned announced on the 17 May 2023 due to

action we took. We then returned to follow up and continue our inspection on the 25 May 2023 due to continued concerns.

What we did before the inspection

We reviewed information we had received about the service since the last inspection, including the provider's improvement action plan. 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

People living at Care @ Rainbow's End were not able to discuss the care and support they received with us. However, we observed care and support being provided to them. We spoke with 5 staff members, including the provider, team leader, senior care assistant and care assistants. We also spoke with 2 relatives and 2 external professionals. We reviewed a range of records. This included care records of 5 people and their medicine records. We reviewed 4 staff files in relation to recruitment and staff supervision and records related to the management of the home. During the inspection we continued to liaise with the provider to obtain additional documents which we reviewed.

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management;

At our last inspection the provider had failed to assess and safely manage risk to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

● Risks to people's safety was not consistently assessed, monitored, and managed. The provider failed to ensure environmental risks were safely managed. Risks identified at the last inspection remained a risk, and we found further concerns. For example, at the last inspection it had been identified the fire panel was displaying an error and hot water temperatures were over the recommended safe range. We found the same risks at this inspection. This meant action had not been taken to ensure the environment was safe for people.
● People did not have care plans to guide staff on how to support people who were distressed or expressing emotional distress. We found 33 records of incidents where people had expressed distress or agitation. On 6 occasions staff had used restraint and on 3 occasions the person had been exposed to risk of psychological abuse. This meant people were at risk of avoidable harm because staff did not have guidance to follow on how to best support people in the least restrictive way.
● People had not received care and support in line with health care professional guidance. For example, a person had respiratory needs and had been prescribed oxygen therapy. Staff did not have guidance or information on monitoring oxygen levels and information about how and when to recognise and escalate any concerns. Staff told us, "[person] requires oxygen every night and it needs to be monitored. The levels need to be over 95%." Daily recording of the person oxygen levels showed staff recording levels had been as low as 6 or 7%. This reading could not be correct because this would mean the person would have passed away. Some nights the oxygen levels were not monitored. The provider told us the person should be monitored every night, the person resists having the monitoring and it is difficult to get a reading. However, the provider failed to put appropriate measures in place to ensure the person received their care and support in line with their assessed needs to keep them safe
● People had equipment to support them with their mobility. However, there were no care plans or assessments in place to guide staff on the reason the person needed the equipment or how to use equipment safely. For example, one person had specialised equipment and the provider did not know if the person had been assessed by an appropriate health care professional to ensure the equipment was appropriate and safe for the person. Staff told us, "We have not been trained to use [person's] equipment." This meant people were at risk of not being supported appropriately and risk of harm.

● Advice from specialist health professionals had not always been obtained in a timely manner. For example, a person had been diagnosed with heart failure and it was known they required regular weight monitoring. The provider had failed to respond when the person had lost 8 pounds in weight in 20 days. No action had been taken until a relative had raised concerns in relation to the unexpected weight loss.
● Some people had known risks with continence care, weight loss and limited mobility. However, no assessments had been made in relation to people's skin integrity. This meant staff were not always aware of how to minimise known risks to people, or identify concerns, which placed people at risk of harm. The provider failed to ensure incidents and accidents were reviewed, analysed, and monitored. This meant the provider failed to identify opportunities to reduce the risks to people's safety and prevent people from experiencing avoidable harm. We found no action had been taken to embed a culture of learning lessons from previous incidents.

Using medicines safely
● Medicines were not managed safely.
● Staff practice was not in line with national guidelines and medicine administration training. For example, one person had been prescribed Buccal Midazolam, this is a rescue medication to support people with epilepsy. The medicine did not have a pharmacy dispensing label to show who the medicine was prescribed for, and staff did not have access to the NHS guidance to guide them on how to administer the medicine. This meant staff did not have instruction in how to safely give this type of medicine or when to give it. This placed people at risk of harm.
● People were not supported to take their medicines without their knowledge (known as covert). There was no care plan or risk assessment completed to guide staff on when and why people needed their medicines covertly. Staff told us, "We try to give medication as normal and if [person] declines we give it on a spoon with food. We do not have a care plan and we do not record when medication is given covertly. We do not have a list of foods the medication can go in or not." Although the provider had received an authorisation from the doctor they had failed to ensure a care plan was in place and staff were not provided with pharmacy guidance on which foods medicines can or can't go in Although the provider had received an authorisation from the doctor they had failed to ensure a care plan was in place and staff were not provided with pharmacy guidance on which foods medicines can or can't go in

● Where people required medicines on an as and when basis (known and PRN), the provider had failed to ensure there was information available to guide staff how and when to support people to take these to ensure the most effective administration of their medicines.
● Staff had not ensured medicines were stored safely and securely in line with best practice guidance. Medicines cupboard keys were observed to be left next to the medicine cupboards. The room where the medicines cabinet was located was also freely accessible by people who lived at the service. This placed people at an increased risk of harm.
● Medicines audits were completed. However, staff failed to identify medicines concerns, errors, or discrepancies. For example, the findings of the last 3 medicines audits were identical, and staff recorded no concerns. This meant the provider missed opportunities to identify potential risks and take action.

Preventing and controlling infection
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. The home and people's equipment were visibly dirty and unclean. For example, a person's mobility equipment had dirt, dried food debris and dried liquid marks.
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection. The provider had failed to ensure there was an effective cleaning procedure and schedule in place. We found bathrooms were dirty, taps had limescale, and mould was present. This meant the provider

did not have a measure in place to prevent, reduce and control infection.
● The provider had cleaning schedules. However, staff did not complete the tasks. For example, the night cleaning schedules were blank and had not been completed. There was no oversight from the provider to ensure the tasks had been completed.
● We were not assured that the provider was preventing visitors from catching and spreading infections.

● We were not that the provider was making sure infection outbreaks can be effectively prevented or managed.
● On the third day of our inspection staff were cleaning and the provider told us the staff had been told to do a deep clean of the home. Although some improvements had been made, taps still had limescale and bathrooms were not clean.

Care and treatment was not being provided in a safe way to people. The provider failed to ensure they were doing all that was reasonably practicable to mitigate risks to people. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider's infection prevention and control policy was up to date.
● 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 was responding effectively to risks and signs of infection.

Visiting in care homes
The service supported visits in line with current guidance.

Systems and processes to safeguard people from the risk of abuse, Learning lessons when things go wrong
● The provider failed to implement an effective system and process to ensure all accident and incidents were reviewed and analysed. Incidents had recurred because the provider did not take action to prevent them. The provider did not review and investigate incidents to identify causes and failed to ensure suitable measures were put in place to prevent a re-occurrence.
● A person had been subject to physical restraint by staff without robust processes and procedures being in place to enable that to happen safely.
●For example, when the person declined to get off their transport bus staff would physically support the person off the bus to, "save time." Records showed incidents when the person declined personal care and staff had physically moved the person from bedroom to bathroom to provide care. There was no evidence of agreement from a multi-agency team that physical restraint support was required.

● Staff were not provided with information or guidance on how to best support people in the least restrictive way. This meant people were at an increased risk of being restrained inappropriately and at risk of harm. We reported these incidents to the local safeguarding authority. We asked the provider to ensure staff were trained and provided with a care plan and risk assessment to follow to ensure staff could respond to people in the least restrict way when supporting people who expressed distress or agitation.
● Staff had received safeguarding training. However, staff were not knowledgeable enough to recognise, and act on, incidents of abuse. For example, when staff noticed unexplained bruising staff had recorded this in daily records. However, staff did not know it needed to be reported and investigated to determine the possible cause. Staff told us, "We used to record it in handovers and do a body chart. Since your visit we are aware it must be reported." We asked the provider to ensure all accidents and incidents are reviewed, analysed, submitted to the appropriate statutory bodies, and continually monitored.

Systems and processes had not been established to protect people from abuse and improper treatment. This placed people at increased risk of potential harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Although, we found widespread concerns relatives we spoke with provided positive feedback. One relative said, "Yes [person] is safe, they are adequately supervised by the staff who look after [person] seem to know [person] very well. I've not known any accidents that have happened. I'm always welcomed and can pop in at any time."

Staffing and recruitment

● Staff could not meet people's care and support needs due to lack of appropriate training. For example, at the time of the inspection staff had not been trained in Makaton (a form of sign language) and people living at the service communicated using this communication method.

● Staff had not been trained in positive behaviour support. Staff told us, "We didn't have any training to support people with their behaviour. We were not supported appropriately to ensure we were trained. Now, since this visit [current CQC inspection] we have had Positive Behaviour Training and the community nurse is supporting now. We have not had any incidents since." Records shared with us since the inspection showed incidents had reduced in frequency.

● Some staff had not been trained in how to support people at the care home who had specific medical care needs. For example, a relative told us, "The main staff seem to be trained with a specific medical need and were trained by hospital staff. The newer staff have not been trained. With this [stoma care] has to be done every six months, but staff are not trained to do that, this is because of the hospital. So, I do that part, I don't mind." The provider could not demonstrate appropriate action and contact had been made with health professionals to ensure all safe were trained.

The provider failed to ensure staff were appropriately trained to meet people's needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider had not ensured staff had been recruited safely. For example, a new staff member had not completed an application form, been interviewed and the provider had not obtained pre-employment references. This meant the provider did not follow their own processes and did not check the staff member was safe to work within the service.

● The provider failed to ensure there was a safe recruitment procedure in place. We reviewed 4 staff files, and all were found to be missing essential information. For example, appropriate background checks had not been completed, no explanation of gaps in work history had been obtained, and no information had been asked regarding staff's physical and mental health to assess if they could properly perform the tasks required of them.

● Although the provider had undertaken Disclosure and Barring Service (DBS) checks on all staff one member of staff had commenced their employment before their DBS had been completed. One member of staff told us they started to work with people on their own from November 2022. However, their DBS check had not been processed and competed until January 2023.

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 requires improvement. 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

At our last inspection the provider had failed to robustly assess and record people's wishes, needs and preferences, in line with the MCA and failed to make best interest decisions. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 11.

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 provider 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.

● The provider failed to ensure consent to care, and treatment was in line with the MCA and guidance. The provider told us, their staff still required additional training on the MCA despite this being a concern at the last inspection in November 2022.
● Although the provider had made some improvements, decision- specific mental capacity assessments had not been completed for all decisions where people's capacity was in doubt. For example, no MCA's had been completed for covert medicines, finances, and personal care where people's capacity to consent was in doubt.
●People's care plans showed they had been written in the person's best interests. However, the provider failed to follow good practice guidance on best interests decision making. Appropriate professionals, and people who knew the people well, had not been consulted in MCA assessments. A relative told us, "No I am

not aware of being involved in any assessment to do with capacity."
● Where people required DoLS applications, these were completed. However, we found where conditions were in place these were not always followed. This meant people did not always receive care and support lawfully, and in line with their best interests.

The provider failed to ensure consent to care, and treatment was in line with the law and guidance. This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
●Although we found some improvements had been made to ensure staff were trained following our last inspection, the provider had not ensured this had continued and been sustained. We found continued concerns around not all staff had receiving the necessary training to ensure people were safely supported.
● A process had been put into place following our last inspection to ensure staff completed an induction when they were first employed at the service. However, the provider had not followed their own process and not all staff had completed an induction.
● Training including, person centred care, care planning, continence care, communication Makaton, Mental Capacity Act and risk assessments had not been completed by all staff. Specific health training on stoma care, nutrition/ fluids & hydration, oxygen therapy and positive behaviour training had not been completed by all staff. Competency assessments had not been carried out for all staff despite the service providing care and support to people living with complex support needs. This left people at risk of being supported by staff without the skills to meet their needs effectively.
●The provider had not ensured all staff were competent. For example, staff told us they had been trained to use restraint. However, staff had only been trained in breakaway training. This was training to support staff if they were in danger themselves, and how they would be able to get themselves out of an incident. This meant staff were using restraint when they had not been trained to do so. This placed people at risk of harm from the inappropriate use to physical restraint.
●Supervisions had not been completed regularly with staff. A supervision provides staff members with an opportunity to reflect and learn from their practice, check competence, and identify training needs. The supervisions had not identified gaps in staff knowledge or improvements required to staff practice. For example, competencies and supervisions did not highlight staff were not monitoring a person's oxygen levels and ensuring they received oxygen therapy as required.

The provider failed to ensure staff were supported, inducted, trained, and had the required skills to meet people's needs This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care plans lacked detail and did not include information about people's assessed needs and preferences, and were not reflective of people's current level of support.
● Some improvements had been made to care plans. However, staff were not provided with care plans and risk assessments in all areas of people's identified care and support needs.
●People who were known to have continence support needs did not have continence care plans. Daily records showed people showed signs of distress during the night and morning when staff supported with continence care because they were sleeping. However, despite that staff continue to check and support people during the night because there was no personalised care plan and risk assessment to guide them with best practice. This meant people were at risk of not receiving care in line with their needs and

preferences.
● Care plans contained conflicting information. For example, one section of a person's care plan said they needed to be weighed weekly and another section of their care plan said daily. Records showed weighing had not been done regularly at either of the intervals. Another person had two medicines care plans kept in different files and had different information for staff to follow. This meant people continued to be at risk of not receiving care in line with their assessed care needs.
● The provider had reviewed care plans since our last inspection. However, they failed to identify care plans were not accurate and reflective of people's care and support needs. For example, where people had experienced distressed periods, we found information had not been updated following these incidents. This meant staff did not always have up to date information about how to provide care and support to people when their needs changed.
● The provider was aware of the issues identified and acknowledged the gaps within people's care plans. They told us full reviews of people's needs were being undertaken and care plans would be updated which would ensure people received care in line with their needs and preferences.

Supporting people to eat and drink enough to maintain a balanced diet
● People who had specialised diets did not have their dietary needs met. For example, one person had been assessed by SALT (speech and language team). Staff had been provided with guidance on the size and consistency the person's food needed to be to protect them from choking. Staff had not followed the guidance and provided food that was not within that guidance. This meant people were at increased risk of serious harm. We took enforcement action and imposed conditions to ensure staff were provided with information and guidance.
●Food and fluid monitoring was in place. However, records had not been reviewed to identify or reduce risks. For example, one person had an identified risk of not eating and drinking enough. Records showed the person had not drunk enough and regularly declined meals. The provider failed to take action and did not provide staff with guidance on what to do if the person did not drink or eat enough. This meant people were at increased risk of malnutrition and dehydration.
● Although people had been offered enough food and drink, the provider did not ensure food was always in line with people's personal preferences and choices. For example, menu planning had been completed by the staff and all the people who lived at the home were offered the same food with no alternative options. When people declined their meals, records did not show whether alternative meals were offered. This meant people did not have choice and control over their meals.

The provider did not ensure people's needs were fully identified or met. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We observed people who were assessed as needing equipment aids to help them eat and drink being used. People who required support with their meals were supported in a caring and dignified way by staff.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
●People were not always supported to live healthier lives as staff did not have detailed information about people's specific health and medical needs.
●Whilst people had been supported to attend health appointments, such as their annual health checks, support plans did not always include outcomes from their appointments. For example, a person had a health review with their doctor and been prescribed medicines for diabetes along with additional information to support the person to manage their condition. However, staff had not recorded the outcome of this appointment in the person's care notes. This meant staff did not have clear guidance on what

instructions were given during those appointments and the person was therefore at increased risk of developing further health conditions related to their diabetes.

●The provider failed to contact other agencies in a timely manner to obtain guidance on how to support people with their emotional and behavioural needs. There was a lack of guidance and strategies in place for supporting people who were distressed and showed anxiety related behaviours to ensure people were kept safe.

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

●The environment was homely. People had personalised their own bedrooms. For example, each bedroom had personal belongings that were important to people.

● A new kitchen had been fitted. The provider told us they had replaced the kitchen as it was in disrepair.

● The provider told us they had plans to adapt the bathroom to meet people's needs

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last inspection the provider did not ensure good governance systems were in place to assess, monitor and mitigate the risks to people or maintain securely accurate or up-to-date records of people's care or the management of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

● People continued to receive a service that was not well-led. The provider did not understand their role, or regulatory requirements, and lacked effective oversight of the service. Issues we found at the last inspection continued to be found at this inspection and had deteriorated. This meant people continued to be at risk of receiving unsafe care and treatment from a poorly run service.
● The provider had not ensured they checked staff competencies to ensure they could safely carry out their role in line with their training and good practice. For example, senior staff were responsible for checking daily records were completed. Those checks were not effective, and staff failed to identify risks to people. The provider was also not checking that these checks were being completed by their senior staff.
●Staff were not able to explain their role and responsibility in keeping people safe, staff told us, "I didn't feel supported. We were told we could use the training [break away] but no guidance in which situations and when we raised our concerns, we were told by the manager to use the training. Now we know that wasn't right."
● The provider failed to ensure they had a safe recruitment process and system. This meant staff had not been recruited safely.
● The provider lacked knowledge of their statutory responsibility in relation to safeguarding and notification requirements. Reportable incidents and accidents had not been reported to the local authority safeguarding team or CQC. For example, staff had used authorised restraint on 6 occasions, and it had not been reported appropriately therefore safeguards were not put into place to protect people living at the service.
●Staff told us the provider had struggled with managing the service and did not always do what they said they were going to do. "I did go to the manager, saying we were struggling with [person's] behaviours and they said they would put things into place. We trusted that assessments and care plans were in place to use the breakaway training like we did [restraint]. But now we know it wasn't and we didn't have any training to

support us or people with behaviours."

Continuous learning and improving care
●The provider failed to sustain and implement systems or processes to monitor the quality and safety of the service. This increased the potential risk to people because quality concerns had not been identified. The provider was not aware of the concerns we identified with the environment, medicine systems, care plans, risk assessments, daily recording, or management processes. This meant the provider had not acted and improve the care.
●The provider failed to put monitoring systems in place to ensure there was effective oversight of the service in relation to care planning, daily recording, risk management, health and safe medicines management. This meant the provider had failed to ensure they had identified risks, concerns and had not improved the care provided.

The provider failed to ensure good governance systems were in place to assess, monitor and mitigate the risks to people, maintain securely accurate or up-to-date records of people's care or the management of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The culture was not consistently person centred, inclusive and empowering. Therefore, people did not consistently achieve good outcomes from their care.
● People were not given the opportunity to choose their care and support because the provider failed to ensure effective communication methods had been used for people to be presented with information in format they would understand.
● The provider failed to ensure staff were provided with information to guide them on how to best support people in line with legislation, good practice, and policies. For example, there was no authorisation, training, policy, care plan or risk assessment in place for the use of restraint.
● Although we identified significant concerns at this inspection, feedback we received from people's relatives was positive. One relative told us, "We have been really happy and [person] seems like they have settled, and I enjoy visiting. I am happy with them, and I wouldn't have him there if I wasn't."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider did not always understand their responsibility in relation to the duty of candour and had not informed relatives when things had gone wrong with people living in the home. For example, when staff had used unauthorised restraints, relative had not been informed. People were not always offered an apology when things went wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider did not formally record any staff meetings which we were told occurred on a monthly basis. However, they told us they engaged with staff by using mobile phone messaging and staff meetings to keep staff up to date. The provider told us they also spoke to staff and that staff did approach them when they needed support.
● The provider told us they had meetings to discuss concerns found from previous CQC and local authority visits and explained procedures that had been put into place. We found these to be ineffective because staff and records could not demonstrate learning had taken place or been understood by both the provider and

their staff.

● Staff did not feel they were listened too. Staff told us, "We had raised concerns regarding [person's] behaviour and it felt like the manager did not believe us."

●Relatives told us they were not invited to review meetings. However, they did feel the provider was engaging and had involved them. One relative said, "Not formally but the manager will be in the kitchen and tell you the plans they have."

Working in partnership with others

● The provider had been working with the local authority. The local authority had completed visits to support the service to drive up improvements since our last inspection in December 2022. However, the provider failed to implement the support, recommendations, and take appropriate action.

● The provider told us they had made contact with professionals however this information and guidance was not available within people's support plans and staff were not aware of the guidance. For example, people had equipment for mobility but there was no information where the equipment had been sourced for and the reason why.

●We found improvements had not been made and risks had increased since our last inspection.