Mr Adrian Lyttle

Mr Adrian Lyttle - Sutton Coldfield

Inspection report

61 Vesey Road
Wylde Green
Sutton Coldfield
West Midlands
B73 5NR

Tel: 01212405286

Date of inspection visit:
20 April 2022

Date of publication:
03 August 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and autistic people and providers must have regard to it.

About the service
Mr Adrian Lyttle – Sutton Coldfield is a residential care home registered to provide personal care for up to nine people with learning disabilities. At the time of the inspection there were eight people using the service.

People's experience of using this service and what we found
The provider could not demonstrate how the service met the principles of right support, right care, right culture. This meant we could not be assured of the choices and involvement of people who used the service in their care and support.

Right Support
The service did not support people to have the maximum possible choice, independence or have control over their own lives.

We found staff were not always supporting people in the least restrictive way possible or in their best interests. For example; we found there was a restriction of the personal money for one person, for which there was no mental capacity assessment or best interest meetings held.

We also identified staff were using inappropriate responses and de-escalation techniques and there was a lack of positive re-enforcement.

We found staff used controlling language and restrictions towards people who were expressing emotional needs such as; hitting out at other people using the service, saying repetitive things to prompt a response or removing footstools from under people's legs as they knew staff would then engage with them. This was in part due to the lack of training and guidance for staff to follow. This meant people using the service continued to display the same behaviours as they had no goals or targets in place and staff had no strategies to follow to decrease such incidents.

We found staff training and record keeping needed to be improved in relation of the use of the Mental Capacity Act 2005 (MCA).

People did not always have the support they needed to meet their needs and keep them safe. This increased the risks to people's health and wellbeing.

Right Care
The service did not have enough appropriately skilled staff to meet people's needs and keep them safe.

People's care, treatment and support plans did not always reflect their range of needs or promote their wellbeing and enjoyment of life.

People who were distressed or expressing emotional distress did not have proactive behaviour strategies in their care records. This meant they did not provide detail on the specific actions staff should take to ensure practices were least restrictive to the person and reflective of a person's best interests.

Right culture
Care was not always person centred and people were not empowered to influence the care and support they received. One person told us, "I am talked through and not to."

The systems for reporting were not robust. For example, where concerns in relation to incidents between people using the service had occurred, staff had recorded these but the registered manager and provider had not taken appropriate steps to identify these incidents and take appropriate actions to mitigate future occurrences.

The provider's governance systems were not always effective. Governance systems did not ensure people were kept safe and received a high quality of care and support in line with their personal needs.

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 Inadequate (report published 06 October 2021) and there were breaches of regulation.
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. We had also received some concerns in relation to the management of the service and the safe care and treatment of people using the service. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements. 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 remained Inadequate. This is based on the findings at this inspection.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Mr Adrian Lyttle – Sutton Coldfield, on our website at www.cqc.org.uk.

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

We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to person centred care, safe care and treatment, safeguarding service users from abuse and improper treatment, receiving and acting on complaints, good governance, staffing and fit and proper persons employed.

Since the last inspection we recognised that the provider had failed to adhere to the conditions of their registration. This was a breach of regulation.

Follow up
We will hold a meeting with 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 remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Mr Adrian Lyttle - Sutton Coldfield

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 completed by two inspectors.

Service and service type
Adrian Lyttle - Sutton Coldfield is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We met and spoke with six people who used the service. We also spoke with seven relatives and two health care professionals. We used a range of different methods to help us understand people's experiences. Some people were unable to tell us their experience of their life in the home, so we observed how the staff interacted with people in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.
We spoke with six members of staff, including care co-ordinator, care staff, the registered manager and the provider.
We reviewed a range of records. This included four people's care records and five people's medicine records. We also reviewed the process used for staff recruitment, records in relation to training, the management of the home including audits.

After the inspection
We continued to seek clarification from the registered manager to validate evidence found. We looked at training data, monitoring records, policies and procedures and quality assurance records. We spoke with two professionals who support people using the service.

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 Inadequate. At this inspection the rating for this key question has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

At the last inspection there was a breach of regulation 12 (Safe care and treatment) and regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the provider was not meeting the regulations.
At this inspection we identified the provider was no longer in breach of regulation 19 but there was a continued breach of regulation 12. We also identified at this inspection, there was a new breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● At the last inspection we found that people's risks were not always effectively managed. At this inspection we found risk assessments continued to not always be effective. For example, where risks to people should have been reviewed and updated following incidents, this had not always happened and meant that people were not safe from the risk of harm.
● People who had been assessed by Speech and Language Therapy (SaLT) because they were at risk of choking, did not have the necessary information accurately recorded in their care records for staff to follow. For example, one person was given a high-risk food to eat. Staff did not follow the SaLT guidelines for supporting the person to eat safely. The person was assessed as needing a specific diet because of their risk of choking, but staff failed to consistently follow this. We brought this to the immediate attention of the registered manager who contacted the SaLT team to seek their advice and guidance in relation to inappropriate foods being given to the person.
● Staff told us that a family member was providing food to a person that was not in line with their assessed needs. The provider had failed to make an appropriate referral to the SaLT team for advice and guidance. This left the person at risk of choking.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm due to the lack of up to date dietary information and guidance. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● We reviewed a selection of Medication Administration Records (MARs) and saw the information for staff members to follow, was not always clear. For example, there was no additional information for staff to follow where the instructions for administration stated to be given 'as directed'. This meant there was the potential for too much or too little medication to be given. We found there were medication discrepancies, for two people, which could not be accounted for. This meant we could not be certain people had received

the correct amount of medication.
● We also found that guidance for staff to follow when administering 'as required' medications were not consistently in place. Some improvements had been made since the last inspection, but some protocols were not clear and robust. Unclear protocols could lead to staff not knowing when to give these medicines which included medications for the control of pain and anxiety.
● Medication which was brought into the service was not booked in using a robust system to identify how much stock of medication there was at any one time. This included medication used for the treatment of pain and anxiety. This meant it was not possible to identify if the medicines had been administered as prescribed.
● We found one person had some medication in their room such as inhalers for the relief of asthma and prescribed creams. The person had been assessed as requiring support with these however, staff told us the person would use these themselves. This meant we could not be assured the inhalers or creams had been used safely and in accordance with their prescription.
● When staff opened medication, they did not always record the date of opening. This is important as some medication has an expiry date once opened. We found that two bottles of eye drops prescribed for one person had been dated when opened, however, we found these were being used past the 'use by' date. This meant the effectiveness of the eye drops could be affected and no longer provide the correct level of treatment.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm from poorly managed medication systems and processes. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The provider had systems in place to look at incidents, however the registered manager did not have oversight of these, and incidents had not been reviewed for at least two months. This meant people using the service were placed at risk, as appropriate actions had not always been taken, to report and reduce the potential of further incidents occurring.
● Incident reports and records used to record people's emotional responses to situations, demonstrated that staff had recorded incidents which had taken place between two people living at the service, but the local safeguarding team had not been notified of these events. Due to the lack of follow up records and monitoring it was unclear if any harm or injuries had been sustained following physical impact.
● There had been no action taken following incidents of abuse to consider what could be put in place to prevent reoccurrences and ensure people were protected. There was no record that any staff discussions had taken place to consider the management of incidents and to discuss inappropriate and abusive staff practices.
● The culture of the service was such whereby incidents of displays of behaviour, were deemed as normal. This meant people were exposed to the risk of harm and abuse including verbal, emotional and physical abuse. Staff had not always recognised abusive practice which meant staff and the registered manager had not taken action to safeguard people. For example; an incident where one person had hit another person on the arm, had not been reported. We spoke with the registered manager about this incident and he advised he was not aware this had taken place. The registered manager told us they would look into this and make the appropriate referrals to the local safeguarding team.
● There was no analysis of incidents and accidents to identify triggers or trends. This meant the provider did not have oversight of the service and information to help them learn from such incidents. This placed people at risk from harm as measures were not put in place to reduce the potential of similar incidents.

Systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm from on-going safeguarding concerns. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff we spoke with told us they had not received regular supervision and did not always feel supported.

● We reviewed staff members recruitment files and found there were some issues identified with the service's recruitment processes. For example; Staff who had been employed by the provider for many years had not had their criminal record status reviewed since their employment began. We saw one staff member had been employed for 19 years without an updated Disclosure and Barring Service (DBS) check carried out. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The provider also confirmed they did not have a current system to review this and had not done so for any long serving staff but would review this. This meant the provider could not be assured staff members had not been convicted of any criminal offences since they had been employed.

●Staff files we looked at had two suitable references, identification or an application form.

● Staff told us they had received an induction when starting work and had the opportunity to shadow other staff.

● Our observations during the day indicated there were enough staff on duty to support people with their care needs. People told us they would like to do more and there were not always the staff to support them when they wished, with fulfilling their interests and hobbies such as going to the football, shopping, swimming and daytrips to places of interest. The provider told us staff had recently supported some people to visit the zoo however, they acknowledged they had not supported people recently to fulfil their hobbies and interests due to staffing restrictions and COVID-19.

Preventing and controlling infection

● At the last comprehensive inspection, we identified significant concerns in relation to the Infection Prevention and Control (IPC) within the service. At this inspection we saw systems were more robust and cleaning was being carried out, in accordance with current IPC guidance for care homes. There were still areas of improvement where refurbishment would make areas easier to clean, such as en-suite shower rooms and chipped paint on handrails.

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

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was 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.

The provider was working in accordance with the government guidance for visitors at the time of our inspection. People and relatives told us they were able to visit loved ones and go out for meals or places of interest when they wished.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating for this key question has remained Required Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. We identified at this inspection there was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also identified at this inspection, there was a new breach of regulation 9 (Person- centred care).

Staff support: induction, training, skills and experience

- Staff trained in medication administration, were taking blood sugar levels for a person who had diabetes. Staff had not had their competency assessed to undertake these duties. This was identified at the previous inspection and placed the service user at risk as staff did not have training or clear guidance available.
- Staff members told us the procedure they would follow to take blood sugar levels. However, the care plans still did not provide staff with clear guidance on how to do this or what the 'normal' blood sugar readings were for this person. This was identified at the last inspection and actions had not been taken.
- Staff had not been trained to fulfil their roles and to ensure they were effectively providing support. One staff member told us, "I have been here over 12 months and have not received training." They also told us that they supported people with swallowing difficulties and catheter care but had not received any training. They said, "There is poor communication and it is a lot of guess work. I have worked in care before and use my knowledge from my previous role to get through." Newer staff members also had not received training specific to individuals known health conditions.
- The training matrix demonstrated that staff members still had not completed training to meet all people's known needs. Similar gaps in training were identified at the last inspection.
- On relative told us, "Staff change so frequently I don't feel staff know [Name] very well, that worries me."
- Staff told us they were not always well supported by the registered manager or the provider. One staff member told us, "Training isn't good, and communication is poor. They [management] are not approachable."

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staff members received the support and training required to support people safely. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff files we looked at evidenced that staff had received an induction and staff members confirmed this. This included an induction into the service and meeting people living in the service. This gave new staff members the opportunity to get to know people and their needs and wishes before working as part of the duty team.

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.

● The provider was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.
● We found staff were not always supporting people in the least restrictive way possible or in their best interests. This included the restriction of the personal money for one person, for which there was no mental capacity assessment or best interest meeting to explore this. Records we looked at had conflicting information as to whether the person did or did not have capacity to make the decision, understand and agree to the restriction on spending money.
● Staff were using responses and de-escalation techniques that failed to positively re-enforce people's responses to certain situations which may impact on their emotional well-being. Staff used controlling language and restrictions to manage people's expressions of distress or a need for attention. This was in part due to the lack of training and guidance for staff to follow. This meant people using the service continued by responding to situations and showing signs of potential un-recognised, anxiety, frustration, boredom, excitement or confusion, as they had no goals or targets in place and staff had no strategies to follow to decrease such incidents.
● We found staff training and record keeping needed to be improved in relation to the use of the Mental Capacity Act 2005 (MCA).
●There was some information in people's care plans around likes, dislikes and choices.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care plan review documents we saw indicated reviews had not identified where changes or incidents had occurred. Care plans were not always updated to reflect changes in a timely way. This meant care staff did not always have accurate information on how to support people safely.
● People and relatives told us they had not met with the registered manager or provider to review their needs and wishes. This meant care plans and risk assessments were not developed to reflect people's up to date needs and wishes.

We found no evidence that people had been harmed however, the provider could not demonstrate they had supported people to engage in hobbies and interest or discussed their current wishes and needs. This placed people at risk of harm from not receiving person centred care to meet their needs and wishes. This was a breach of regulation 9 (Person centred-care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● Although people told us on the whole, they were happy with the food, one person said, "We have chips

every week, they never change it. I would like lasagne, fruit salad and milk shakes."
● We did observe that there was fresh fruit available in the dining area for people to access. During lunch time and preparation of the evening meal we did not observe staff members encourage people who were able to, to get involved with helping.
● One relative told us they were concerned there were not enough healthy food options. They told us, "[Name] had put a lot of weight on during lockdown, I had an issue as they did not seem to do anything to encourage exercise and they [people] all put weight on. I have asked [Name] the provider if they offer healthy choices and they said 'yes'. I know they could do better with the food choices sometimes."
● Menus demonstrated the provider offered a varied diet. However, there were no records to demonstrate people using the service had been involved in developing the menus. The provider told us they had been consulted and the menu was reflective of people's choice and preferences.
● Staff monitored people's weight however, where people were at risk due to a high BMI, this had not been identified and there was no evidence provided, to demonstrate the registered manager had sought advice from a dietician. This placed people at risk of obesity and other related illnesses.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● One health professional told us that staff members were good at identifying when they needed help and support and other health professional said, "They [management] are pro-active and responsive." However, on inspection we found instances where referrals to the palliative care teams, to help people with end of life care and Speech and Language Therapists (SaLT)to help with people's eating and drinking had not always happened in a timely way.
● People told us they were supported to access healthcare services when needed such as the GP and dentist.

Adapting service, design, decoration to meet people's needs
● Further refurbishment was needed throughout the home and the decoration was in need of repair and attention. We saw that there were still holes in walls and broken windowpanes around the home. This meant people were potentially placed at risk of harm.
● An audit of the environment, which was completed by the care co-ordinator, did not identify the areas in need of decoration and new fixtures. The provider had no current plans for when these improvements would take place. They told us they had found it difficult to find a glazier to replace the broken stained glass windows. We will review the progress of these plans at our next inspection.
● One person told us that they were unhappy with their bedroom. We could see that this was having a negative impact on their levels of anxiety throughout the day. When we spoke with the provider they could not demonstrate where people's choices were reflected in the layout and decoration of their own rooms.
● We saw people making use of the garden, although there was no structured engagement for people to be involved with or pursing their interests and hobbies.

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 Inadequate. At this inspection the rating has remained 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.
At the last inspection we identified a breach of regulation 17(Good governance). At this inspection we found there was a continued breach of regulation 17 (Good governance). The provider had not embedded the new systems they had implemented or maintained effective governance within the service. We also identified a new breach of regulation 16 (Receiving and acting on complaints).

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The service has a history of not meeting the regulations. This demonstrated that the provider does not have a culture of sustained improvement.
● Following the inspection, we carried out on 28 June 2021 (report published 06 October 2021) the service was rated as Inadequate and there were breaches of regulation 12 (Safe care and treatment), regulation 17 (Good governance), regulation 18 (Staffing) and regulation 19 (Fit and proper persons employed).
● The inspection on 17 February 2020 (report published 20 March 2020) and there were breaches of regulation 12 (Safe care and treatment) Systems in place did not ensure the risk of fire was effectively managed. The overall rating for the service was requires improvement.
● The inspection on 11 May 2016 identified breaches of regulation 13 (Safeguarding service users from abuse and improper treatment). The provider had failed to comply with the Mental Capacity Act 2005 because key processes had not always been followed to ensure that people were not unlawfully restricted.
● At this inspection enough, improvement had not been made and the provider was still in breach of multiple regulations.
● We are currently in the process of reviewing information to establish if the provider had failed to adhere to the conditions of their registration which had been imposed following the last inspection.

● Due to on-going personal circumstances, the registered manager was not in the service on a full time basis although they were contactable by telephone or e-mail.
● The provider had failed to ensure there was suitable management oversight of the service in the registered managers absence, which has contributed to the shortfalls identified. The provider and registered manager had failed to demonstrate that they understood the principles of good quality assurance and this meant the service lacked any sustained and effective improvement.
● Although there was a system to audit aspects of the service, we found that the provider had failed to carry out their own audits or monitoring of the service to ensure people were supported in a way they chose and safely. If they had carried out their own checks and audits, they may have identified the concerns with care plans and risk assessments which required more robust information and medication issues, which we identified.

● The management of safety, risk and governance had not been effective. Actions had not been taken by the provider or registered manager to ensure the systems and processes were robust and operated effectively.
● Care records and risk assessments still required more detail to ensure information was detailed and current for staff to refer to. The provider's own audits had failed to identify these shortfalls. Although there were records to evidence when reviews of care plans and risk assessments took place, we found they were not effective as the concerns we found had not been addressed. This included; missing health care plans, lack of information for staff to follow and unclear risk assessments.
● Checks of the building and equipment safety were completed; however, these did not include actions taken when concerns had been identified. For example, in relation to broken windowpanes and holes in the walls. The provider's audit process did include actions to be completed. However, we found these were not always completed therefore identified issues had not been addressed.
● Audits had failed to identify the medication discrepancies and lack of information in care plans.
● The provider had failed to implement and operate systems ensuring all staff had the knowledge, training and skills to carry out their roles correctly and safely.
● The provider had failed to review or renew long standing staff members criminal records checks. This meant they could not be assured staff members supporting people remained to be of good character.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the service was well managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
● There was no evidence of action been taken to resolve issues raised in complaints received or that the provider had monitored these for recurring themes to help them improve the service. The provider told us they had not received any complaints. Staff and relatives, we spoke with, told us they had raised concerns with the registered manager and provider but felt they were not always listened to. One relative told us, "They respond to the concerns sometimes, depending on what mood [Name] the provider is in." Another relative told us, "I raise a lot of concerns with [Name] registered manager as I would like [Name] to look a little better when she comes out. I have raised a complaint."
● The provider nor the registered manager had oversight of the incident records completed by staff thus, no actions had been taken in relation to the actions staff were taking, in response to people's emotional and physical responses to situations. This meant staff continued to use inappropriate measures to 'control' people and no lessons had been learnt.
● Relatives we spoke with said they found that the communication was poor. One relative told us, "Something needs to change drastically, we are hoping communication will improve". Another relative told us, "They [staff] do let us know if [Name] goes to the GP, this has happened recently but was not happening before." We found no evidence that people had been harmed however, the provider had failed to operate an effective complaints system. When we discussed this with the provider, they told us they had not received any complaints since the last inspection, from relatives.

This placed people at risk of harm from recurring themes. This was a breach of regulation 16 (Receiving and acting on complaints) 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We found from documentation, that the service did not always promote a person centred approach.

People's individual needs were not always considered or met. Such as; activities and interests were not always met. The provider told us this was due to COVID-19 restrictions and staffing levels as they had struggled to recruit and retain staff. Due to the lack of engagement and stimulation, we saw people potentially sought responses to situations by verbal and physical expressions of potential boredom to gain a response or reaction from staff members or other people using the service. Two people using the service told us they would like to go out more rather than just use the garden.

● We did not see any evidence of meaningful engagement for people's known interests and hobbies taking place other than people using the garden. The registered manager told us they had implemented a wish tree for people to indicate what they would like to do and places they would like to go. They told us they had recently been to the zoo and parks and had been out for meals.

● Relatives also told us they felt more could be done to stimulate their loved ones. One relative told us; "They [staff] look after people but do not stimulate them. [Name] needs more stimulation to have the best life possible and she is not getting that. [Name] is just existing, getting up, sitting around, watching TV and vegetating. I have said this to the providers a lot, but nothing has changed."

● Relatives also told us they had not been invited to attend care reviews to discuss the continuing care and support of their loved ones. This meant the provider could not be assured the care plans and risk assessments reflected people's current needs and wishes.

● Although the registered manager told us they had sought feedback from relatives and health professionals using feedback forms they had not received any completed feedback forms.

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

● Prior to this inspection, we were made aware of concerns people had about the care and support people received. Some of those concerns were confirmed during this inspection.

● Staff we spoke with told us that they did not always feel supported by the management team and told us they were not approachable.

● The provider was not displaying their most recent inspection rating as they are required to by law, however, this was changed during the inspection.

● The registered manager and provider were not always completely open and transparent during the inspection. Although they did recognise that further improvements were needed at the home and showed a willingness to listen and improve, they felt the issues identified were due to staff not following procedures.

Working in partnership with others

● The registered manager told us they worked well with the local GP, pharmacy service, health and social care professionals and the local authority. However, we found they did not always seek timely guidance and support from some health professionals, as peoples care needs changed.

● People told us they were supported with their appointments and records of health professional visits supported this information.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Service users were placed at risk of not being supported in a person centred way, with reasonable adjustments in place, and provided with support to help them understand and make informed decisions about their care.

The enforcement action we took:

A Notice of Decision was issued to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not robust to assess, monitor and mitigate risks to the safety and welfare of people using the service. The provider had failed to ensure that risks to people were effectively managed. People were exposed to risk of harm due to unsafe risk management systems including; a) Poor medicines management and lack of detailed information. b) Care plans and risk assessments for peoples known health conditions were either not in place or not detailed sufficiently to guide staff to provide safe support. c) Choking risks due to foods other than in accordance with peoples assessed dietary needs being provided.

The enforcement action we took:

A Notice of Decision was issued to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care	Safeguarding service users from abuse and improper treatment Service users were placed at risk of not being supported in a person centred way, with reasonable adjustments in place, and provided with support to help them understand and make informed decisions about their care.

The enforcement action we took:

A Notice of Decision was issued to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to operate a robust complaints system. The provider failed to keep a record of complaints received. There was no evidence of action been taken to resolve the issues or to enable them to monitor for recurring themes to help them improve the service.

The enforcement action we took:

A Notice of Decision was issued to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were inadequate. Potential risk and areas of improvement were not identified. The provider had not ensured governance arrangements within the service had been operated effectively thus; the provider had failed to identify the concerns we found during the inspection. Governance systems were not robust to effectively assess, monitor and mitigate the risks of the health, safety and welfare people and staff who use the service

The enforcement action we took:

A Notice of Decision was issued to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure all staff had received up to date training thus staff did not have the knowledge and skills to support people safely.

The enforcement action we took:

A Notice of Decision was issued to cancel the providers registration.