Mitchell's Care Homes Limited

Nutbush Cottage

Inspection report

Bonehurst Road
Horley
Surrey
RH6 8PP

Tel: 01293823620
Website: www.m.ch.co.uk

Date of inspection visit:
22 November 2023
23 November 2023
28 November 2023

Date of publication:
22 January 2024

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
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 supported to develop ways to reduce their anxiety and distress in situations they found difficult. Robust safeguarding processes were not followed which meant people were not fully protected from the risk of potential abuse. Risks to people's safety and well-being were not always recognised or acted upon.

People had limited opportunities to do things they enjoyed or develop interests and did not benefit from an interactive, stimulating environment. People spent long periods of time in their rooms, walking around the house, watching films or listening to music. Staff had not explored people's communication needs or developed plans to support people in being more involved in their own care and support.

Improvements had been made in the way medicines were managed and safe systems were now in place. People were generally supported by sufficient staff who were recruited safely. The building of an office in the grounds of the home had led to a decrease in one person's anxiety. People lived in a clean and comfortable environment.

Right Care: People were not always treated with dignity and their privacy was not always protected although some individual interactions with staff were kind. Staff did not demonstrate an understanding that Nutbush Cottage was people's home and did not always treat people as equals. People were not involved in the running of their home in a meaningful way and choices in respect of meals and how to spend their time were limited. People were not always supported to develop skills and independence.

Although improvements had been made to the monitoring of healthcare appointments, advice provided from healthcare professionals was not always followed and staff were not fully aware of people's healthcare needs.

Right Culture: The ethos, values, attitudes and behaviours of leaders did not support people to lead confident, inclusive and empowered lives. The provider had failed to develop a skilled staff team who understood how to support people in a person-centred way. The principles of the Right Support, Right Care,

Right culture guidance was not embedded into the culture of the service and audit systems were not in place to monitor this.

A task based approach had developed which did not focus on supporting people to live fulfilled lives. This has not been identified by the manager, as there was a lack of provider oversight and support for the manager.

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 (6 July 2023) and there were breaches of regulation. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We have found evidence the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has remained inadequate based on the findings of this inspection.

Enforcement
We have identified breaches in relation to people not being protected from abuse; people not always receiving safe care and treatment and staff not having the appropriate training to meet people's needs effectively. We also identified breaches in relation to the staff not always being caring and respectful, people not being supported to do things they enjoyed, people not receiving personalised care and a lack of robust management and provider oversight.
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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

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. The current manager had applied to register with CQC but had withdrawn their application prior to the full assessment being completed. They informed us they intended to re-apply at a later date.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
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 sought feedback from the local authority and professionals who work with the service. We used this information to plan our inspection.

During the inspection
We spoke with 1 person and 2 relatives about their experience at Nutbush Cottage and received feedback from 3 professionals. For those people who were unable to provide verbal feedback about the support they received we observed their interactions with staff and each other throughout the inspection visits. We spoke with 7 members of staff including the provider, senior management team, the manager and care staff. We reviewed a range of records. This included 4 people's records relating to their care, finances and medicines. We looked at 3 staff files in relation to recruitment, training and staff supervision. A variety of records relating to the management of the service, including, audits, policies and procedures were 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 inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to ensure robust systems were in place to protect people from the risk of abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

Systems and processes to safeguard people from the risk of abuse

- Relatives told us they felt their loved ones were safe living at Nutbush Cottage. One relative told us, "[Relative] is happy there. I think he didn't like anything there I would know from how he is."
- Despite these comments we found that robust safeguarding processes were not followed to keep people safe. The provider had reported a safeguarding concern raised by staff to CQC and the local authority who had asked for additional information. Prior to sharing this information, the provider undertook their own investigation and acted upon their findings without further discussion with the local authority. The internal investigation lacked detail and had not fully explored the concerns raised. This meant the provider could not assure themselves the correct action had been taken to ensure people's safety.
- The local authority told us they did not always receive prompt and comprehensive information from the provider in relation to safeguarding concerns. We spoke with 2 professionals who told us they had experienced delays in receiving responses and difficulties in contacting the management team.
- Staff were not always trained prior to starting to support people. A review of training records showed 2 staff members had not completed safeguarding training prior to working with people. Staff we spoke with understood the need to report concerns to the management team. However, they were not all able to describe what types of concern they should be aware. This meant they may not recognise concerns and therefore not report them as required.
- Robust finance systems were not in place. We identified one person had been charged a considerable amount for household laundry which they were not required to pay as they were living in a care home. The manager had signed to confirm this transaction was correct. The money was re-imbursed when we highlighted this error.

The failure to implement and follow robust safeguarding processes was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Improvements had been made in the management of finances for one person. Staff were now recording mileage which was reviewed against the petrol the person used.

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

At our last inspection the provider had failed to ensure robust safety and risk management systems were in place. 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 in relation to the implementation of risk management systems.

● People were not always supported to prevent or manage their anxieties. Two people living at Nutbush Cottage experienced anxiety over situations which occurred regularly. Staff did not recognise the impact this had on the people concerned and were not clear on what action they should take to support them. There was no guidance available for visitors regarding how they should respond to people who approached them when anxious.
● People's Positive Behaviour Support (PBS) plans lacked detail regarding how to support people with their anxiety. One person was known to become upset when others used the bathroom. Despite this being a long-standing concern, there was no record of this within the persons PBS plans and no guidance for staff on how to support the person or others when this happened.
● Incidents were not consistently recorded, monitored or reviewed to ensure risks to people's well-being were addressed. We observed 2 people show signs of distress on numerous occasions during our inspection. None of these concerns were recorded in people's daily records and no monitoring had taken place. However, daily records referenced one person showing distress by shouting, screaming, being upset, or crying on 32 of the 83 days reviewed. Reasons for this were not recorded, and no analysis of these incidents was completed. This demonstrated an approach to recording incidents and monitoring which did not result in staff identifying opportunities where they could support people's well-being more effectively.
● Staff did not always have the knowledge or skill to support people when they were anxious. When one person became anxious due to the bathroom door being closed we noted another person living at Nutbush Cottage stood by an internal door to deter the person from leaving the room to gain access to the bathroom. They told us they sometimes had to do this to keep others safe when staff didn't know how to handle the situation. The 2 staff members present did not intervene to offer support to either person.
● Risk assessments were not reviewed when circumstances changed. One person's support plan and risk assessment stated there was a risk of them leaving Nutbush Cottage without support. This put them at risk, particularly as the property was on a busy main road. During our inspection we found the electronic gates were broken and were left wide open for prolonged periods on 2 occasions when the person was in the garden. Staff did not recognise this as a risk and no risk assessment had been implemented. The manager and regional manager gave assurances this would be addressed with staff to ensure the persons safety. On our third visit to Nutbush Cottage the gate was closed.
● Guidance from professionals was not always followed to keep people safe. One person had been assessed as requiring their food to be of a soft consistency which was easily mashable with a fork. Despite this we saw from records and the person's menu plan they were offered foods including pizza, nachos and salad. This put the person at risk of choking. We have shared these concerns with the local authority and requested urgent assurances from the manager and provider in relation to this. They informed us that all staff had been issued guidance and were completing appropriate training in how foods should be prepared.
● Not all health risks were known to staff. One person's records highlighted a specific health issue which staff needed to be aware of. The manager and staff were not aware of this issue and there was no guidance in place of signs staff should look out for that the person may be becoming unwell.

The failure to implement and follow robust safeguarding processes was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection the provider had failed to ensure sufficient staff were available in line with people's

needs and that the hours staff worked did not present risks to people. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was no longer in breach of this regulation in relation to these concerns.

● Staffing requirements had improved. The provider had reviewed people's care hours with funding authorities and had come to arrangements regarding staffing ratios. Rotas showed these hours had been met and staff confirmed this was the case.
● There were sufficient staff available to meet people's needs. We observed staff were available to people. The manager told us they would make themselves available when additional support was required, and records confirmed this was the case. However, we found this took them away from their managerial duties for a considerable number of hours each day.
● The number of consecutive hours staff worked had been reviewed. This had led to recent changes in shift patterns to help ensure people were receiving support from staff who were not working excessive hours and had regular breaks.

At our last inspection the provider had failed to ensure safe recruitment checks were completed. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was no longer in breach of this regulation.

● Staff were recruited safely. Recruitment checks included obtaining references for new starters and checks using the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

At our last inspection the provider had failed to ensure robust medicines management systems were in place. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was no longer in breach of this regulation in relation to the management of medicines.

● People and relatives told us they were confident in staff skills in administering medicines. One person told us, "I get my meds on time; staff recognise that this is important."
● People received their medicines in line with their prescriptions. Each person had a medicines administration record (MAR) in place which contained an up-to-date photo along with relevant information. There were no gaps in recording and daily stock checks were completed. This meant staff were able to monitor if people had received their medicines as required.
● Medicines were stored and monitored safety. The medicines cabinet was organised and clean with each person's medicines stored in their own compartment. Regular checks of expiry dates were completed. Staff had completed competency assessments in relation to medicines and felt their knowledge had increased.
● Where people were prescribed medicines to be taken as and when required (PRN) this was clearly recorded. PRN protocols were in place which described when people's medicines should be administered. This was clearly recorded on MAR charts when administered.

Preventing and controlling infection

At our last inspection we found the provider had failed to ensure high standards of hygiene and infection prevention and control. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was no longer in breach of this regulation in relation to infection prevention and control.

● People were protected against the risk of infection. Additional cleaning had been implemented which had led to areas of the home being cleaned to a higher standard. Maintenance work had also been carried out which meant staff were able to clean more effectively.
● Staff had access to personal protective equipment and were aware of how and when this should be used to minimise the spread of infection.

Visiting in care homes
● People were able to see their visitors without restrictions and in line with best practice.

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 inadequate. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

At our last inspection the provider had failed to ensure best practice guidance was followed. This was a breach of regulation 9 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 9 in relation to the implementation best practice guidance.

- People's care and support was not in line with Right Support, Right Care, Right Culture guidance. As detailed within this report, people were not supported in a way which took into account of what was important to them, supported them to achieve goals and ensured they were treated as equals.
- Although some staff told us they had received training in Right Support, Right Care, Right Culture guidance they were unable to describe how this informed how they supported people. Staff told us they believed the training was around people's care being person-centred but were unable to describe or give examples of what this meant to the individuals they supported.

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

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure best practice guidance was followed. This was a breach of regulation 9 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 9 in relation to the implementation best practice guidance.

- People were not supported by skilled and well-trained staff. Training records showed that some staff had completed training in areas including safeguarding, risk management, supporting people with autism, communication and record keeping. However, we found there were continued concerns in these areas and that staff lacked skills and understanding. The provider told us they had developed quizzes to test the knowledge of staff in important areas. Of the 10 staff listed as working at Nutbush in the past 3 months, 3 did not appear on the list and 4 had not completed the quizzes. This meant the system was not effective in assessing staff competence in their roles.
- Staff training was not robustly monitored. The manager was unable to assure themselves of what training

staff had completed. The monitoring sheet they had access to contained the names of staff members who no longer worked at Nutbush Cottage and current staff were not listed. They told us they did not have access to the training system to review staff training had been completed. We requested the provider update the monitoring sheet. This showed not all staff had attended training sessions despite having been employed by the provider for some time.

● Staff supervisions were not effective in ensuring staff were supported to develop their skills. The manager told us staff supervisions mainly took the form of reflective practice discussions when concerns were identified in performance. Notes for a number of staff were identical and lacked clarity in the information provided. Supervisions did not give an opportunity for staff to discuss their overall performance, gain feedback or receive support. There was no system in place to set objectives for staff to support them in developing in their role.

● Staff had not fully completed the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. Although some staff had completed the online training elements of the Care Certificate, the manager was unable to provide evidence they had completed the competency elements to ensure they had full understanding of their responsibilities.

The failure to ensure staff received effective training and supervision is a repeated breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider had failed to ensure people's health care needs were robustly monitored. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Whilst some improvements had been made at this inspection, we found the provider was still in breach of regulation 9 in relation to people's health care needs.

● Advice from professionals was not always followed and staff were not always aware of people's health needs. This put people risk of receiving unsafe care. As reported within the safe and responsive areas of this report, information from Speech and Language Therapists was not always followed and staff were not aware of one person's health needs. This put people risk of not receiving support as recommended by professionals for their safety and well-being.

The failure to ensure advice received from professionals was followed is a repeated breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In other areas we found improvements in monitoring people's health had been made. People had been supported to attend routine appointments such as dentists, chiropody and eye checks. Where follow-up appointments were needed this was planned and recorded by staff.

● Annual health checks and medicines reviews were completed with people's GPs. This helped to minimise the risk of health needs not being identified. Records of the last appointments were maintained by staff and relatives updated with relevant information.

● People told us they felt well supported with their health care needs. They told us, "I feel my health has improved since I have lived here because staff look after me."

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

At our last inspection the provider had failed show respect for people's home. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was no longer in breach of regulation 9 in relation this.

● Adaptations had been made to the premises to reduce people's anxiety. The provider had built a separate office building in the garden area. This meant that staff no longer needed to complete administration tasks in the dining room which one person had found difficult. Whilst the person continued to show anxiety in relation to other things, the new office had clearly had a positive impact.
● People's home was now more comfortable for them. New furniture had been purchased for the lounge and people's bedrooms. This included new recliner chairs so people could relax in their rooms should they wish. Although areas were more comfortable, people's home needed more personalisation to create a more homely feel. The manager was aware of this and said they were being supported to develop ideas further.
● People had access to a garden. We observed people used the area to get some fresh air and to ride their bikes safely.

Supporting people to eat and drink enough to maintain a balanced diet
● People received support to eat and drink enough to maintain a balanced diet. Staff prepared regular meals and offered drinks throughout the day. Although people appeared to enjoy their food, choices were not always offered. We have reported on this within the caring area of this report.
● One person chose to make their own snacks and drinks and kept these in their personal cupboard in the kitchen. Staff respected this and were on hand to offer the person support should they need it.
● People's weight was regularly monitored. Records showed that people had maintained their weight and no concerns had been raised by healthcare professionals in relation to this.

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● People were receiving care in line with the principles of the MCA. Capacity assessments had been completed in relation to aspects of people's care including consent to care, medicines, finances and support with health care. Where people's lacked capacity to make decisions, family members who knew them best, staff and health professionals were involved in best interest decisions.
● DoLS applications had been submitted to the relevant local authority in line with requirement. This included applications being submitted prior to DoLS authorisations expiring. At the time of our inspection no one living at Nutbush Cottage had an authorised DoLS in place.
● Staff were aware of the MCA and that it was used where people lacked capacity for certain decisions. Although they were unable to describe the whole process, they knew they needed to seek support when decisions impacting on people's care were needed. We did not observe staff restrict people's movements during our inspection.

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 Inadequate. The rating for this key question has remained 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

At our last inspection the provider had failed to ensure people were treated with dignity and their privacy respected. This was a breach of regulation 10 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 this regulation.

● People and relatives described staff as caring. One person told us, "It's more family-like here than where I used to live, and staff are looking out for me." One relative told us, "The manager and the other staff member I have met seem very good and caring."
● As found at our last inspection, whilst we observed kind individual interactions, the overall culture of the service was not always respectful and caring towards people and their home. Staff were seen to spend time walking around Nutbush Cottage with minimal interaction as though they were patrolling rather than spending time with people. We observed one mealtime where one staff member sat to support people and the remaining 2 staff members stood over the table. One was leaning against the window, and one was stood with their hands behind their back, providing occasional instructions for people to slow down or to take a drink. This appeared institutionalised and did not encourage a mealtime where people could relax.
● At our last inspection we highlighted the large medicines cabinet being in the dining room was not appropriate and did not create a homely atmosphere. At this inspection we found the medicines cabinet had been moved into the lounge. This had been fitted directly in the vision of where a person spent much of their time standing by the window.
● People's dignity was not always respected. We observed one staff member approach a person in the lounge to check if they needed the bathroom by looking down their trousers. There were four others in the room at the time including another staff member and an inspector.
● The need to ensure people's privacy had not been embedded and understood. The downstairs toilet and shower room had no blind or covering at the window. Although the glass was obscured, people were clearly visible when it was dark and the light was on. The window looked over the new office area, laundry and part of the car park which was also accessed by people in 2 supported living flats. We asked the manager about the reason for this. They told us as CQC had only identified concerns with a different window at our last inspection, they had not addressed the bathroom. This demonstrated a lack of understanding regarding their responsibility to ensure people's privacy and dignity.
● Staff did not always take time to listen to people in a respectful way. One person was speaking to a staff

member for some time. The staff member did not appear to engage in the conversation and walked away from the person without excusing themselves.
● Language used by staff in care notes was not always appropriate of dignified. Records contained terms such as absconding to describe people leaving their home without support, home leave when people went to visit their families and described one person as, 'refusing to calm down'. These were all terms found during our last inspection which continued to be present in people care records.
● People were not consistently supported to develop their independence. One relative told us of a significant achievement in gaining independence their relative had made when they came to live at Nutbush Cottage. However, since that time there was limited evidence people had been supported to gain skills and independence in their daily lives.

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

● We observed some staff share positive interactions with people. For example, one person appeared more relaxed when one staff member was around. They spent time with the staff member watching them cooking and engaging with them. From the communication and jokes they shared it was clear they had developed a positive relationship.

At our last inspection the provider had failed to ensure people were involved in decisions about their care. This was a breach of regulation 9 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 this regulation.

Supporting people to express their views and be involved in making decisions about their care
● Steps had not been taken to support people in planning their care in a meaningful way. Care plans reflected people had been asked to be involved in reviews but did not say how or what different ways had been tried such as the use of photographs or pictures. For example, one person's notes stated, 'I have involved [person] in reviewing [their] care plan and [they] was more interested in watching [their] cartoon on [their] iPad.' Relatives told us they were not involved in the process of updating and reviewing their loved one's care plans although the manager would discuss any concerns with them.
● People did not have meaningful choices in respect of day-to-day decisions such as how they spent their time or what they chose to eat. Staff told us they had developed a new person-centred menu plan. They told us pictures of the different meals had been added so people were aware of what was available. However, this had been completed on a 4-week rolling menu plan rather than people choosing what they wished to eat on a daily or weekly basis. The pictures used were very small which meant it was difficult for people to see what the option was. The manager told us staff had access to larger photos of meals on cards but staff said this was not the case.
● Choices regarding how people spent their time were generally made by staff without people's involvement. The manager told us 'Activity Plans' had been developed with each person living at Nutbush Cottage to include things they enjoyed doing. One person told us they had not been involved in this process and were unaware of what the plan said. They told us some of the things written on the plan were not things they would enjoy or were physically able to do.
● People were not involved in the running of their home in a meaningful way. Residents' meetings were held although much of the detail for the months of August and September was identical. These were also almost identical to minutes we had reviewed as part of our last inspection in April 2023. This included the one-word responses people had made. These were generally out of context to the question and did not demonstrate staff had presented information in a way people could relate to. There was no clarity regarding how staff

encouraged involvement from people, what visual aids were used, discussions regarding what people had achieved or what they were happy with.

The failure to ensure people were involved in decisions about their care was a continued 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 inadequate. The rating for this key question has remained 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

At our last inspection the provider had failed to ensure people's needs and wishes were met and to ensure people had opportunities to go out and do things they enjoyed. This was a breach of regulation 9 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 9 in relation to these concerns.

● Relatives told us it was important for their loved ones to go out regularly. One relative said, "I would like to see him getting out every day. It's really important for his health." A second relative said, "I hope he goes out a lot, I'm sure he does."
● People were not supported to go out on a regular basis. Although staff told us activity plans had been developed, these were not reflective of how people spent their time. One person's weekly schedule stated they were due to go out 10 times each week. Records showed that apart from a week's holiday and visits with family, the person had been out on only 3 occasions over an 11-week period.
● Hours provided as part of people's care package to enable them to go out were not fully utilised. One person received funding to go out daily. Records showed that apart from a week's holiday and visits with family, the person had been out on only 14 out of a possible 50 days over the same 11-week period. Most of these outings were for less than the funded time. Following the inspection we reported these concerns to the person's funding authority.
● People were not supported to develop their interests or take part in things they enjoyed. There was a lack of variety and interest in what people were supported to do when going out. People's records showed the majority of time they went out this was for a drive and/or a walk. Things listed on people's plans such as cinema, visits to the pub, bingo, meals out and buggy rides only happened occasionally.
● Records did not fully reflect what people had done. Standard icons on the electronic recording system were not used correctly to record activities. This meant activity charts did not give an accurate refection of what people had done. This included using the icon for walk to describe someone going in the garden or using the icons for horse-riding or swimming to record this had been cancelled.
● People were not supported to develop their interests when at home. People continued to spend the majority of their time on their tablet devices, watching television or walking around their home.
● People's support plans were not followed. At our last inspection we reported staff were not following guidance from the Speech and Language Therapy team to encourage a person to do other things rather

than spending their day using their iPad. At this inspection we found the guidance had still not been implemented and staff were not aware of this despite it forming part of the persons care plan. One staff member told us, "[They] finish using it when it is time for [their] night time snack. When [they] gets up, in the morning [they] will go straight away to get it. I don't think that there is any limit on when [person] uses it."
● Goals and aspirations were not discussed or set with people or their families. We asked one person how they were supported to develop goals. They told us, "I don't know what my goals are. I can't say what my goals are here." We asked the manager how they supported people to set goals. They told us they had started this within people's care plans. They were unable to describe anything they had found people would like to work towards. There was no evidence within care plans that people had been supported to set goals.
● People were not routinely involved in a range of daily living tasks to develop their involvement and skills. Records showed that, with the exception of doing their laundry and taking their dishes to the kitchen, people were not encouraged to take part in the running of their household on a regular basis. Staff did the majority of cooking and cleaning with little involvement from people.

The failure to ensure people's needs and wishes were met and the lack opportunities for people to go out and do things they enjoyed was a repeated 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.

At our last inspection the provider had failed to ensure people's communication needs were met and recommendations followed. This was a breach of regulation 9 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 9 in relation to people's communication needs being met.

● People's communication plans lacked detail and did not describe how people were supported to make choices or understand what was expected of them. In some cases, they detailed words or gestures people may make but did not describe what these meant to people or how to respond to them.
● Alternative communication methods such as different visual aids, objects, sign language or the use of electronic communication packages had not been fully explored. The majority of people living at Nutbush Cottage used limited verbal communication. Pictorial 'Activity Plans' had been developed for each person. The pictures were very small, and no work had been undertaken to see if the pictures were meaningful to individuals. Staff told us one person moved the pictures around, so the boards were not accurate. We did not see staff use the boards when communicating with people. This demonstrated a lack of understanding regarding people's communication needs being personal to them.
● Staff told us they had recently completed Makaton training to support them communicating with people. However, no one's communication plan stated they used Makaton and we did not see staff use this communication method during our inspection.
● Staff lacked skills in supporting people to transition and prepare for what they were doing next. Guidance from the Speech and Language Therapist stated staff should use a particular communication system when supporting one person to transition between tasks. Staff we spoke with were not aware of this system and told us they did not use this. This had also been the case at out last inspection. There was no evidence attempts to gain skills or understand the system had been made by staff.

● People's communication plans did not always contain details of how to prepare people to go out to minimise their anxiety. We observed staff tell one person it was time to go out and to get their shoes and coat on. When they had completed this the staff member then told the person they had decided they should have lunch first. The person stood up to eat their lunch and showed anxiety and confusion about what was happening.

The failure to ensure people's communication needs were assessed and effective systems to support them implemented was a repeated 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

● The provider had a complaints policy in place which was available to people and their relatives. Records held by the manager showed no concerns had been raised since our last inspection.

● Relatives told us they would feel comfortable in raising concerns with the manager and felt they would respond. One relative told us, "I would flag anything I was worried about straight away. I speak to [manager] most weeks so we would work it out."

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. The rating for this key question 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 our last inspection the provider had failed to embed a positive and inclusive culture and to ensure robust management oversight. 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.

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

- Relatives and staff told us they felt the service was managed well. One relative told us, "I think [manager] is good. [Relative] is happy to go home and that's always a good indication." One staff member said, "I feel valued, the manager and owner tell me this. They are always thanking me for the work I do."
- Despite these positive comments, we found there was a continued lack of understanding regarding how to create and maintain a positive culture where people were supported to achieve good outcomes. The provider, manager and staff were unable to demonstrate an understanding of personalised support where people were at the centre of the service.
- The provider had failed to ensure the manager had the skills required to move the service forward, develop staff understanding and embed safe, effective and responsive practices. The provider acknowledged the service still needed to work to ensure staff understood their roles in providing personalised support. We asked the provider how they had supported/mentored the manager to gain the skills they required. The provider told us they had recommended the manager used social media for this, "So for instance, they can go on YouTube and put in, 'how to offer someone 4 choices' then when they understand that they can observe staff and give them guidance on how to do it." This demonstrated a lack of understanding of people's individual needs, how to provide person-centred care and how to support staff to develop skills in these areas.
- There was a lack of provider and managerial oversight. The management team informed us that good progress had been made with people keeping busy, going out more and doing new things. However, records did not confirm this was the case and there was no evidence of how the provider or manager reviewed this.
- Quality assurance systems were not effective in monitoring the service people received. Audits were not comprehensive and focussed on the environment and forms used rather than being used to review people's quality of life. Where concerns regarding staff interactions with people were made in audits, it was not clear how these were addressed or monitored.
- Action plans arising as a result of internal audits lacked detail and did not consider the support the manager may need to complete these. The provider told us they had employed a regional manager to

support managers in their roles as they recognised this as a need. At the time of our inspection the regional manager had been in post for approximately 2 weeks and had originally been employed to support a different service. Prior to this, no additional steps had been taken to fill this role whilst recruitment took place.

● Unrealistic expectations had been set in response to an external audit report. An external auditor had been commissioned following our last inspection. A long action plan and report had been developed in response to the shortfalls identified. This had been produced in June 2023 and contained almost 200 actions, many with a completion date of less than 4 weeks. Over 150 of these actions were assigned to the manager. There was no note of how they would be supported to complete these and no assessment of their skills to do so. Many of the actions had not been completed at the time of our inspection.

● Where action plans reflected concerns had been addressed, no checks of the quality the work had been undertaken by the provider. The audit stated that people's care plans had been reviewed and changed to make them more personalised. We found during our inspection, people's care plans were lacking in detail and did not guide staff on how support people in a holistic way. Further audits of revised care plans were completed by the manager who had written them which meant the quality of the plans were not objectively reviewed.

● The provider had failed to ensure that records relating to people's care were accurate and reflective of their needs. Daily notes were task orientated and did not reflect people having a positive experience or good overall quality of life which focussed on their skills and achievements.

● The external audit completed in June 2023 had recommended care records be audited. We observed this process had started the day prior to our inspection in November 2023. The provider told us they were aware staff were using the icons and set phrases on the system rather than inputting a record of what people had been doing. They stated they had told staff not to do this although there was no evidence of what on-going monitoring had taken place to ensure changes were implemented. We found these practices continued at the time of inspection.

The failure to ensure robust quality assurance processes were in place was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In other areas we found the provider had made improvements which had led to positive changes to people's lives. Investment in the property to build an office in the garden and to purchase new furnishings had meant people were more comfortable in their home.

● Audits and training implemented in relation to medicines practices had resulted to more robust systems being implemented. This had led to people now receiving their medicines safely.

● Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the service. The provider had completed notifications in line with this requirement.

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

At our last inspection the provider had failed to ensure views of people, relatives, representatives, staff and professionals were acted upon. This was a breach of regulation 17 of the. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider had failed to implement systems to gain feedback from people living at Nutbush Cottage.

Provider audits contained few comments in relation to how people were supported, how choices were provided or the effectiveness of communication from staff.

● Staff were not fully involved in the running of the service. Staff meeting minutes reflected issues that were shared with staff rather than being used as an opportunity to develop skills and teamwork. Team meetings did not cover people's support or care but were centre around when staff should inform of sickness and the need to follow rotas.

● The provider was not always fully transparent when sharing information with relatives. Although families had been informed of recent safeguarding concerns, they had been told police and internal investigations were complete with no concerns noted. However, they were not informed the local authority was still to complete the safeguarding investigation, so the process was not complete.

● The provider did not have good oversight of incidents within Nutbush Cottage. Following our last inspection, additional monitoring charts were implemented to enable times when people showed anxiety and distress to be monitored. The provider had failed to identify this system was not being used by staff and was therefore unaware of concerns.

● The provider and manager did not always provide information to professionals in a timely way. One professional told us, "I have found it difficult to get responses from them, even to basic questions like the management structure. I have identified the issue of leadership within both Nutbush Cottage and the wider organisation as an ongoing risk factor."

The failure to ensure people, relatives and staff were fully involved in the service and received open and transparent information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider sought feedback from relatives. This was requested on a regular basis and demonstrated relatives were happy with the service provided.