

Valorum Care Limited

# John Masefield House - Care Home with Nursing Physical Disabilities

## Inspection report

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## Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

# Summary of findings

## Overall summary

### About the service

John Masefield House is a residential care home providing accommodation for persons who require nursing and personal care for up to 22 people in a single storey building. The service provides support to adults with a physical disability. At the time of our inspection there were 19 people living at the home.

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.

At the time of the inspection, the location did not care for or support anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

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

#### Right Support

Staff did not always have the information required to provide safe and effective care. Care plans and risk assessments did not always contain relevant, up to date information within them.

People were supported safely with most medicines. Topical medicines such as creams were not always applied as directed.

People were supported by staff who had been safely recruited. The provider completed police checks and gained references for staff prior to them starting work.

Staff received an induction before working with people.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

#### Right Care

Risks to people had not always been mitigated. We found concerns with risk associated with health conditions, including risks from pressure damage, choking and moving and handling.

Not all staff had received the appropriate training to understand people's individual needs, such as people with a learning disability and/or autistic people.

## Right Culture

The leadership and management of the service had been inconsistent with frequent changes leading to inconsistency in support and practices in the home. People and their relatives were concerned about this and the impact on those living in the home.

Systems and processes were not always effective in ensuring the registered manager and provider had effective oversight of the service.

Systems were in place to gain feedback from people, relatives, and staff.

The provider responded to requests for information during the inspection and implemented measures where concerns had been identified to improve the safety and quality of the service.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

## Rating at last inspection and update

The last rating for this service was requires improvement (published 1 September 2022) 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

This inspection was carried out to follow up on action we told the provider to take at the last inspection. The inspection was also prompted in part due to concerns received about the management of the service.

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 John Masfield House on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

## Enforcement and recommendation

We have identified breaches in relation to safe care and treatment, person centred care, staffing and good governance at this inspection.

We have made a recommendation about specific training requirements.

Please see the action we have told the provider to take at the end of this report. 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 ask for an action plan and meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## Special Measures

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

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will act 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 to their registration.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate** ●

The service was not safe.

Details are in our safe findings below.

### Is the service effective?

**Requires Improvement** ●

The service was not always effective.

Details are in our effective findings below.

### Is the service caring?

**Requires Improvement** ●

The service was not always caring.

Details are in our caring findings below.

### Is the service responsive?

**Requires Improvement** ●

The service was not always responsive.

Details are in our responsive findings below.

### Is the service well-led?

**Inadequate** ●

The service was not well-led.

Details are in our well-led findings below.

# John Masefield House - Care Home with Nursing Physical Disabilities

## **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 3 inspectors and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

### Service and service type

John Masefield House 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. John Masefield is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

### Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage

the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

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

#### During the inspection

We spoke with 14 people who used the service and 9 relatives about their experience of the care provided. We spoke with 10 members of staff including, the operations manager, registered manager, nurses, team leaders, support workers and the chef.

We reviewed a range of records. This included 9 people's care records and multiple medication records. We looked at 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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.

# Is the service safe?

## Our findings

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

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

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Practice at the service placed people at risk of harm. Not all risks relating to people's health and safety were adequately assessed and safely managed. Information about the risk associated with people's needs or guidance, was not always available to care staff. The lack of accessible, clear and up to date guidance for staff put people at risk of unsafe care.
- The service had not ensured risks to people from nutrition and hydration were adequately assessed or documented in line with national guidance and not all staff were aware or adequately trained to support people eat and drink safely. We saw records in April 2023 stating that a member of staff responsible for providing food had not had formal training and this was required. At the time of our inspection, formal training had not been provided or booked for the chef to attend. This meant people were at risk of inaccurate diet textures and drink consistencies that could cause choking. The area manager arranged this training immediately after being informed.
- One person was at risk of aspiration (when food or drink are breathed into the lungs). This was because the most recent guidance from health professionals had not been updated in all the person's records. Not all staff we spoke with were aware of the latest guidance which put the person at risk of aspiration.
- The service had not properly managed equipment related risks. A person who had moved to the service 14 days before the inspection did not have the equipment in place to keep them safe from the risk of falls as stated in their care records. The provider ensured specialist equipment was implemented immediately in the form of a floor sensor.
- There was not always equipment of a sufficient quantity to ensure the safety of people and meet their needs. At least 3 ceiling hoists were not working in people's rooms that required hoisting. There was only one mobile hoist in place on the first day of the inspection. On the second day, another mobile hoist had been delivered. A relative commented, "Response to the call bell can be much too long, hence [person] can end up with soiled clothing which makes more work and is very degrading for [person]."
- A fire 'grab bag' was available by the fire point in reception. Grab bags contain information about how people can exit premises in the event of fire and are used in an emergency to guide services to those who need assistance first. We looked in the grab bag and there were no plans for the 2 most recent admissions. The providers audit had stated that these were in place. The registered manager was informed of the missing information and put them in place.
- Systems were not always effective in ensuring people were protected from the risk of abuse. During the inspection we saw there were times when people had injuries and other reportable incidents which had not been notified by the service to the CQC and other relevant bodies such as the local safeguarding board. This meant there was no assurance that incidents were being investigated and acted upon appropriately by the provider. Following the inspection, the service director made a retrospective referral to the local



safeguarding authority and reported they had implemented a new electronic incident reporting system, to help further improve governance of incident reports.

The failure to ensure people received a safe service was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Safe Care and Treatment.

- The provider responded on the day and shortly after the inspection to ensure the above findings were rectified.

#### Staffing and recruitment

- The service had not ensured there were a sufficient number of suitably qualified, competent, skilled and experienced persons to meet people's needs.
- Most people required support with eating their meals at lunchtime. We observed people having to wait a considerable time until care staff were free to support them with their meals. People told us they often had to wait, and one comment was, "Bells often taken about 30 minutes to be answered". We observed on the day a member of staff attending to the call bell, switching it off, and then leaving the room to do something else and not returning. Relatives commented, "I feel that my relative is safe, but the staff do not have sufficient time allocated to sit and chat to residents to promote good mental health."
- Staff felt there were just enough staff to meet people's needs but felt frustrated with the provider's programme of employing internationally recruited staff who came to work in the home for 3 months and then moved on to another service. Staff said they felt that they had invested a lot of time supporting the care staff, only for them to move on and be replaced by further staff who required training. They felt that this, along with the use of agency staff, had impacted on the ability for them to carry out some of their roles. One staff member commented, "When they only stay 3 months, they just get used to the routine etc and then [the provider] brings another group in and you start all over again." The lack of consistent staffing and permanent staff having to support a new intake of staff on a regular basis, meant people were not always supported by staff with the time to meet their assessed needs at all times.

The registered person failed to evidence that there were sufficient, suitably supported, and skilled staff. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing.

- Recruitment checks were carried out including a Disclosure and Barring Service (DBS) check which provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

#### Using medicines safely

- Safe medicine practices were not always promoted. We observed one member of nursing staff retrospectively countersigning PRN protocols with a previous date. These findings were reported to the registered manager and regional manager who took immediate action.
- Some medicines such as barrier creams were applied by care staff and records of application were recorded on records in people's rooms. These records showed that creams were not always applied at the prescribed frequency and barrier creams were recorded as 'not required' when it was prescribed as a preventative measure to protect their skin from damage.
- Staff were suitably trained to administer medicines and checks on their practice had been carried out.
- Medicine records (other than for creams) were maintained, and checks indicated people had been given their medicines as prescribed.
- Where people had been prescribed additional medicines on an as required (PRN) basis. PRN protocols

were in place, and contained information to guide staff around why people might require additional medicines.

- Temperatures of clinical rooms and medication storage areas including medicine fridges were monitored. Records of disposed medicines were kept.

#### Preventing and controlling infection

- We were not assured that the provider was supporting people living at the service to minimise the spread of infection through safe use of personal protective equipment (PPE). A person was in their bed with a tummy bug. We saw staff enter the person's room to administer medicines with no gloves or aprons on.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. A relative commented, "The home had lacked cleanliness but since employing a new cleaner this has greatly improved."
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider's infection prevention and control policy was up to date.

#### Visiting in care homes

CQC had received concerns prior to the inspection that there had been some restrictions on visitors. This was raised with the provider at the time. At this inspection, we noted no concerns over visiting restrictions from people and their relatives when asked. A relative commented, "No problems with visiting. Communication with the home has improved a great deal in the past few months since the arrival of a very competent administrator."

# Is the service effective?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to 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 the last inspection systems were either not in place or robust enough to ensure people received person-centred care. This was a breach of Regulation 9 (Person-centred care) 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

- The provider had not ensured people's needs were fully assessed and could be met prior to their admission to the service. Not everyone's care and treatment needs and preferences had been assessed by people with the required levels of skills and knowledge for particular tasks. For example, a person had been assessed and admitted to the service with very complex nursing needs without all the required equipment and adjustments in place to support them in line with their needs. The assessment was conducted by the registered manager who did not hold a clinical qualification. This meant the person was at risk of not having the quality of care they required in line with their needs.
- The provider's Statement of Purpose states, 'Visiting health care professionals will continue to provide any additional physiotherapy, occupational and speech or language therapy that an individual might need.' At the time of the inspection we were informed people had not received any physiotherapy input since November 2022. One person's records stated, 'Follow my mental health and physio care plan'. However, there was no physiotherapy care plan in place. People commented, "I used to have physiotherapy but now not at all" and "I find exercise helpful but no physio at all." Relatives commented, "I think [relative] would benefit from physio to help with [their] mobility and posture. The current owners have only provided this intermittently over the years. They are now offering physio which residents will have to pay for. I could be wrong but think the physio was provided free of charge to residents in the past" and "I raised the lack of physio with the CEO when he did a flying visit. His answer was 'It's expensive'."

The service had not designed care and treatment with a view to ensuring people's needs were met. This was a breach of regulation 9(1) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Person centred care.

- After the inspection we were informed a physiotherapist was due to start and in the interim a temporary physiotherapist was being deployed.

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

- Risks associated with eating and drinking were not always effectively managed. The International Dysphagia Diet Standardisation Initiative (IDDSI) framework provides descriptions of food textures and drink thicknesses to improve safety for people with swallowing difficulties. Kitchen staff were not aware of this guidance, when asked, and were not able to tell us what people's required safe levels of food and drink were. This meant people were at risk of inaccurate diet textures and drink consistencies that could cause choking. The provider took action to ensure that the chef had adequate training in place.

The provider failed to ensure people's needs were assessed, monitored or managed safely. This was a breach of regulation 12 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 - Safe care and treatment.

- People reported enjoying the food. Comments included, "All you have to do is ask. If I don't like the menu, I can say what I want. It's all made from fresh. I like a lot of salads and Mediterranean vegetables", "Food is good and can get it anytime" and "New chef is good. She's been here 2 months. Makes nice food or can make something else. I keep snacks in my room." Relatives also commented on the improvement in food with comments including, "The latest cook is very good. [Relative] enjoys the food" and "The food has certainly improved since the new chef arrived."

Staff support: induction, training, skills and experience

- Training for working with people with a learning disability or autistic people had not been carried out in line with the legal requirement introduced in the Health and Care Act 2022 on 01 July 2022. E-learning had been undertaken but there was no evidence of how the provider assessed each member of staff as to what level of training staff required in their roles. At the time of the inspection, there were no people being supported with these needs.

We recommend the provider refers to current guidance about requirements of training for all levels of staff.

- Staff received an induction and training. Training was delivered through a mix of online courses and face to face sessions.
- Health care staff were checked to ensure they continued to meet their professional standards.

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

- John Masfield House was a single storey building with large individual bedrooms and communal areas. The service had expansive gardens which were being maintained.
- The building had not made adaptations to meet all people's needs where they had full access to all areas of the home in line with their equipment to mobilise freely.

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

- Some people received input from a variety of health and social care professionals such as GPs and speech and language therapists in response to their specific needs. However, we did not always see guidance provided from these professionals had been recorded within people's support plans to ensure staff were aware of their updated needs.

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.

- Where people were assessed as not having capacity to make decisions, best interest decisions were made, and meetings (where applicable) were held. These decisions had been recorded in people's care plans.
- The provider had a DoLS tracker in place to monitor applications and these were monitored to ensure the least restrictive options were maintained so people were not overly restricted.

# Is the service caring?

## Our findings

Ensuring people are well treated and supported

- People felt that although most of the staff were kind and respectful, they were impacted by inconsistent support due to the lack of continuity of staff.
- The provider had not been able to demonstrate the importance of ensuring staff had the time to give people support when they needed it. Staff were not spending time with people for a meaningful length of time. We observed the activity room throughout the day. There was a lack of staff engaging with people and we mostly observed people just sat in front of the television. One person commented, "Staff haven't got time to sit with us. There is often no staff in the rooms."
- We had comments from people's relatives about the care of their loved ones. These were in relation to high staff turnover and care staff not knowing people as a result, limited nail care and their relatives appearing unkempt at times. The relatives had made the new deputy manager aware of their concerns who had made a commitment to address these concerns.
- We did receive some positive comments from people about care staff. These included, "The regular staff are caring. It's a nice, friendly home" and "I am happy here."
- People felt they were treated with dignity and respect during care tasks. Comments included, "If I'm having a wash, [care staff] put a towel over me to protect me from view", "Nurses help me with dressings and put a towel over me" and "They do good personal care for us."

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

- The provider had not always ensured people's preferences were taken on board, or properly respected. Where services provide food and/or drink, people must have a choice that meets their needs and preferences as far as is reasonably practical. We saw one person had not been supported to receive their preferences in respect of their diet. This was raised with the provider immediately and rectified with an apology issued to the person concerned.
- The provider had not done everything to make sure that people who used the service received person-centred care and treatment that was appropriate and met their needs in communicating in a way that people understood. The provider had shown a commitment to recruiting a diverse workforce from both within the United Kingdom (UK) and internationally. Internationally recruited staff were subject to pre-employment checks and language assessments prior to coming to the UK. However, comments were raised throughout the inspection from people, staff and relatives about a perceived language barrier with some internationally recruited staff that they felt impacted clear communication. People told us that they struggled to always understand or be understood when communicating with the internationally recruited staff.
- Comments from relatives included, "I do have concerns about safety when there are staff on that cannot speak very good English. Residents cannot understand the staff and vice versa, it can make things very difficult for everyone" and "Communication with the [internationally recruited staff] is limited and [person] finds it frustrating getting them to understand. I have raised this with the [registered manager]."
- We asked people if they had shared these concerns with management. One commented, "I tell [registered manager] all the time" and "I tell [registered manager] and she says we just have to wait until June when they will leave."

Respecting and promoting people's privacy, dignity and independence

- The provider did not always make sure that schedules were organised so that people received care and support in a timely manner. We reported in the Safe section of this report that call bells were not always appropriately responded to as we observed these being attended to, but staff then leaving and not returning. This meant the reliability of information from the call bell audit did not accurately reflect whether staff were meeting people's needs in an appropriate time frame. For example, if they needed support to use the lavatory. This could compromise people's dignity.
- Staff supported people to use communication aids to share their views and opinions. These were fully charged and operational during our inspection and people used them when they chose.
- People's independence was promoted where possible. We saw a person collect their food from the kitchen at lunchtime. One person told us, "When dressing, I can do top half and staff do bottom half."
- People were enabled to make as many choices for themselves as possible, and staff ensured they had the information they needed.

# 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 requires improvement. At this inspection the rating has remained requires improvement. This meant people's needs were not always met.

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

At our last inspection the provider had not always planned and delivered care and support in a way to reflect people's individual needs and preferences. Care had not always been designed to ensure people's communication needs were detailed and recorded to improve their communication. These issues were a breach of Regulation 9 (Person-centred care) 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.

- The provider had not ensured that people using the service had care or treatment that was personalised specifically for them to ensure this was person-centred, appropriate, met their needs and reflected their personal preferences.
- People's goals or ambitions were not fully supported or reviewed to see if they were still relevant and accurate. We asked one person about their goals, and they said, "I want to do a [activity]. A staff member was helping me to build up strength but then she got sacked. [Staff member] said I'm not allowed (to do activity) but I don't know why." This meant people were not always supported to follow their interests or encouraged to take part in social activities relevant to their interests.
- Staff providing care had not always been kept up to date with any changes to people's needs and preferences. Not all care plans were made available to staff providing support as they had not been printed off and staff did not have access to computers where these were stored. The information that was in people's care records were not always accurate. Relatives commented, "We have had reviews and issues have been raised, though not necessarily carried out" and "Care plans were done a while back; if anyone ever reads them." This meant care plans were not in place to sufficiently guide staff on people's current care, treatment and support needs.
- The provider had not always used nationally recognised evidence-based guidance when designing, delivering and reviewing care. For example, considering a person's needs that required specific equipment in place. People's care and support did not reflect current evidence based guidance in specific areas.
- The provider had not ensured all people had the necessary information about their care and treatment. We asked people if they had been involved with and aware of what was in their care plans. Comments included, "I don't know about a care plan. Don't know what's in it or what it says." Another person said, "I had a red folder which had stuff about personal care in it, but it broke. I'm not sure if I was involved in writing the care plan and where it is kept." This meant that people were not always involved in developing their care plan to



take into account their individual needs and circumstances.

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 not always planned and delivered care and support in a way to reflect people's individual needs and preferences. These issues were a breach of Regulation 9 (Person-centred care) 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.

- The provider had not always supported people to follow their interests or encourage them to take part in social activities relevant to their interests or maintain personal or community relationships.
- Comments from people included, "We don't really have activities. We do a lot of colouring, don't get asked what we might like to do", "I get bored with it", "There is nothing to work this [pointing to their head]."
- Relatives also expressed concern about people not having enough to do to reduce social isolation. Comments included, "[Relative] needs more stimulation than is available and goes to [activity] which I provide transport for. Friends and family initiated a trip to the wildlife park a month or so ago and will organise a trip to Portsmouth shortly. The initiative for outside trips is hindered by lack of drivers from the home and training on how to secure wheelchairs etc in the minibuses" and "There has been very little (mostly weekend) provision for activities, and this has impacted greatly on the residents. I understand an appointment as activities coordinator starting 24 June has been made. I only hope they stay."
- There were people living at the home who could not easily leave to do activities as the transport was not adapted to meet their needs. This meant unless they arranged their own specially adapted transport, they were not able to access the same facilities as others in the home.

The provider failed to ensure people were provided with appropriate person-centred care that met their preferences. This was a continued breach of regulation 9(1) 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 (AIS). The AIS tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People had communication care plans. We asked a member of staff about whether people's communication care plans were accurate and helpful. They responded, '(Communication plans) were "rubbish but we are working on them".'
- Not all people got the assistance they needed to understand information clearly. One person said, "I can't read some of the signs and I have to ask staff 'what does that say?' They're too small." They also felt they needed improvement in respect of communication with staff. They said, "Sometimes I press the call bell and I forget what I want. Staff don't give me time to speak. Some will stay with me and ask but some won't."
- The service had not fully implemented the Accessible Information Standard to identify, record, flag, share and meet the information and communication needs of people with a disability or sensory loss.

Improving care quality in response to complaints or concerns

- The provider had a complaints policy in place. People told us they would speak to relatives, staff or the registered manager if they had any concerns.
- Relatives we spoke with were confident that if they had a complaint or concern this would be explored and responded to. Comments included, "I have over the years reported a concern which was dealt with appropriately. But such is the rapid turnover of both managers, and deputy managers and trusted, employed carers, that it is hard to rely on consistent presence/contact."

#### End of life care and support

- Where appropriate we saw people had an advanced care plan in place. We saw that a person had been seen by a palliative care nurse and that an end-of-life care plan had been discussed with the person and their relative. End of life medicines had been prescribed and obtained but were not required at the time of the inspection.

# Is the service well-led?

## Our findings

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

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

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

At our last inspection we found the provider did not effectively operate systems and processes to ensure compliance with the regulations and there was a continued breach of regulation 17 (Good governance).

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

- The provider had not effectively operated their systems and processes designed to mitigate risks to people. For example, although audits to assess, monitor and improve the quality and safety of the service had taken place there had not been sufficient oversight of these to drive the necessary improvements. An audit carried out for the provider in January 2023 identified that people did not always have up to date and accurate support plans and risk assessments in place. At the time of the inspection, 5 months later, these were still not in place. This put people at unnecessary risk of receiving unsafe care.
- The provider had failed to operate an effective system to ensure there were enough staff to keep people safe and meet their needs. We asked management for a staff dependency tool and were provided with a document called 'rota rationale'. There was no clear calculation about how the number of staff had been agreed as a safe level of staffing in line with people's care and support needs including support with eating and drinking. There was no reflection of the time required to deliver personal care in line with ceiling hoists not working and the number of staff to operate a manual hoist. Staffing requirements had not been calculated in line with the impact on existing staff to induct and support internationally recruited staff on an ongoing basis.
- Not all records relating to the care and treatment of each person using the service were fit for purpose. The provider had not ensured records were up to date, accurate and complete. Records to evidence that people's care, and treatment were being delivered were incomplete. These included repositioning records, people's weights to inform where interventions were required, equipment checks, food and fluid records and regular checks on people.

The provider failed to ensure the quality, safety and leadership of the service. This placed people at risk of harm. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good Governance.

- Following the inspection, the provider put in place a new management team to take immediate action to make the required improvements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- This was the sixth inspection, since the provider registered the service, where it has been rated as requires improvement or inadequate. The provider failed to ensure there was consistent managerial oversight of the service's systems and processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of people.
- We received mixed feedback on the management of the service. Some staff told us they were not happy with the management of the home. A member of staff commented, "There is no guidance, we don't have a deputy and after 6 months the managers leave."
- Relatives provided feedback about the inconsistency of management of the service. Comments included, "I don't know why the managers keep leaving but get the impression that they are scapegoated by the management higher up and are not supported or trained to the level needed to make the home run efficiently. Many other treasured members of staff have left but no reasons have been given" and "Management is very worrying. Why is it changing every few months? Full of promises that never come to fruition, no consistency or continuity. I'm sorry to say Valorum leave a lot to be desired as a care home, full of empty promises."
- We received positive comments from relatives about the administrator. A relative stated, "[They] have always filled the gap that the constant turnover of managers creates. [They] really care and shows excellent commitment to the residents. [Administrator] is always accessible and can be trusted to pass info to managers or residents."

Engaging and involving people using the service, the public and staff

- The provider had sought the views of people using the service, their families, staff and stakeholders. However, this feedback had not always been acted upon for the purposes of improving services. A service user satisfaction survey had been sent out in March 2023 and analysed stating how feedback was going to be used. However, one person told us they had provided feedback and had not had any response to this to date. Staff views had also been sought in a survey in March 2023.
- A family survey had been completed. Issues identified including language comprehension with the internationally recruited staff between their relative. Another issue was the lack of regular physiotherapy. The issue of activities was also raised as an issue. The actions for this were discussing with people about what they wanted to do. They were also recruiting a second activities co-ordinator.
- A member of staff told us that staff meetings were held and that issues were able to be raised with the registered manager, at these meetings or sooner if needed. However, action was not always taken in response to concerns raised citing an issue that had been brought up about inequity of staff breaks for those who smoked. They commented, "Smoking is a problem, (the registered manager) has been told many times but nothing is done. She needs to be stronger. People take advantage of her." A member of staff also said what was needed was, "A manager and deputy who can ensure people (staff) work to their job description; we haven't got that at present."

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

- The provider had a policy on the duty of candour. A relative told us, "During covid I wasn't told that [relative] had (covid) and found out by accident. I received an apology."
- The provider was working with the local authority to address known areas where improvement was necessary.

- Staff worked with health professionals to help ensure good health related outcomes for people.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	<p>The provider had not designed care and treatment with a view to ensuring people's needs were met.</p> <p>The provider failed to ensure people were provided with appropriate person-centered care that met their preferences.</p> <p>Regulation 9 (1) (2)</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	<p>The registered person failed to evidence that there were sufficient, suitably supported, and skilled staff.</p> <p>Regulation 18 (1)</p>

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Care and treatment was not always provided in a safe way for people. The provider failed to ensure risks to people were fully assessed, doing all necessary to reduce risks and to make improvements.  The systems and processes to ensure risks were identified and managed safely were not always robust enough to demonstrate safety was effectively managed and to reduce potential risks.  Regulation 12 (1) (2)

### The enforcement action we took:

A warning notice was served on the provider to ensure significant improvements were made to the quality of care by a certain date.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not fully assessed, monitored and taken action to improve the quality, safety and leadership of the service.  Records were not all accurate and complete to evidence the care, support and treatment provided to each person.  Systems and processes were not operated effectively to ensure compliance with regulations. Not all information had been evaluated to improve the provider's practice.  Regulation 17 (1) (2)

### The enforcement action we took:

A warning notice was served on the provider to ensure systems and processes were operated effectively to

ensure compliance with regulations.