Badgers Lodge Limited

# Badgers Lodge

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
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| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

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

About the service
Badgers Lodge is a nursing home that provides personal and nursing care to up to 10 people with complex learning disabilities or mental health and physical health care needs. At the time of this inspection there were 10 people using the service.

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

Right Support
• The service did not provide care and support in a well-equipped, well-furnished and well-maintained environment that met people's sensory and physical needs. However, people were able to personalise their rooms.
• People did not benefit from an interactive and stimulating environment. There were equipment/tools available to support this, but lack of communal space and cluttered rooms meant they could not always be used effectively.
• Staff were not always able to support people to take part in activities and pursue their interests due to lack of staff and issues with the physical environment at the property.
• Staff supported people with their medicines, but these were not always stored appropriately.
• Staff supported people to make decisions. However, documentation was not always clear. We have made a recommendation about mental capacity assessments.
• The service worked with people to plan for when they experienced periods of distress so their freedoms were restricted only if there was no alternative.
• Staff enabled people to access specialist health and social care support in the community.

Right care
• The provider had not enabled staff to give people kind and compassionate care.
• The service did not always have enough appropriately skilled staff to meet people's needs and keep them safe.
• People could not always communicate with staff and understand information given to them because not all staff knew them well and understood their individual communication needs.
• Staff promoted equality and diversity in their support for people.
• Staff understood how to protect people from poor care and abuse. The service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
• People's care, treatment and support plans reflected their range of needs.

Right culture
• People did not always receive good quality care, support and treatment. Although staff were trained and understood best practice in relation to how to support people living at the service they did not always have time to provide care that was tailored to individual needs.
• Some staff knew and understood people well and were responsive, supporting their aspirations to live a quality life of their choosing. However, staff turnover meant people did not always receive consistent care from staff who knew them well.
• People and those important to them, including advocates, were involved in planning their care. However, this was not always reviewed regularly by staff involving the person and their families.
• The service did not always take action in response to the views of people and those important to them. We have made a recommendation about the complaints process.
• We have made a recommendation about end of life care planning.

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

Rating at last inspection
The last rating for the service under the previous provider was requires improvement, published on 30 January 2019.

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

Enforcement
For enforcement decisions taken during the period that the 'COVID-19 – Enforcement principles and decision-making framework' applies, add the following paragraph: We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to staffing levels and competency, meeting people's individual needs and personal care as well as the systems to ensure management of risk, incident reporting, and governance processes to monitor and improve the service.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Details are in our safe findings below.

At our last inspection under the previous provider we rated this key question good.

### Is the service effective?

**Requires Improvement**

The service was not always effective

Details are in our effective findings below.

At our last inspection under the previous provider we rated this key question good.

### Is the service caring?

**Requires Improvement**

The service was not always caring/ not caring.

Details are in our caring findings below.

At our last inspection under the previous provider we rated this key question good.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Details are in our responsive findings below.

At our last inspection under the previous provider we rated this key question good.

### Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Details are in our well-Led findings below.

At our last inspection under the previous provider we rated this key question requires improvement.

# Badgers Lodge

**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 Care Act 2014.

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
Two inspectors and an Expert by Experience carried out the inspection. 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
Badgers Lodge 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. Badgers Lodge is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection, the manager was applying to be the registered manager.

Notice of inspection
We visited the service twice, once on a weekday, followed by a weekend visit. Both visits were unannounced.

What we did before inspection

We reviewed information we had received about the service, including feedback from the local authority. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

Where people were unable to talk with us, we used observation to help us understand their experience of using the service. We spoke with eight people's relatives about their experience of the care provided.

We spoke with 16 members of staff including the home manager, regional operations director, clinical lead and training director (RNLD), and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included two people's care records. We looked at three 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one professional who had visited the service.

Requires Improvement

# Is the service safe?

## Our findings

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

At the last inspection under the previous provider this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Staff did not always have the skills to meet the needs identified in people's personalised risk assessments. For example, some people were on specific diets. We observed one care worker intervene to give a colleague advice over the thickness of food. Another care worker told us they had concerns about the preparation of people's food. They said, "There have been some meals with lumps which I've taken out, what if I wasn't there?"
• During the pandemic the provider took emergency measures because five permanent staff were self-isolating. This meant people were not always supported by staff who understood their needs and risks well. For example, people at the service had high moving and handling support needs and required intensive support from staff to move safely. For a short period during this time the service was staffed by people who did not meet these needs. However, this was an unprecedented situation and not representative of usual arrangements.
• Staff did not always complete checks or take action to minimise risk to the safety of the living environment and equipment in it. Some rooms were very cluttered, and we found two pieces of equipment were overdue a portable appliance test (PAT). (PAT) is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.
• Staff recognised incidents but did not always report them appropriately. We identified two during our inspection which the managers were not aware of. One related to two service users on special diets who were given each other's meals, the other involved a service user missing a hospital appointment. A relative gave an example of an accident that had occurred which had not been shared with staff the following day. They told us, "When accidents happen details are not passed on."

Systems were not robust enough to ensure that peoples current risks were safely managed and mitigated, and accidents and incidents were not always reported. This placed people at risk of unsafe care. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• When incidents affecting people's safety had been reported to the manager systems were in place to manage them. A report was completed monthly where themes were identified.
• People's care records were easy for staff to access and update. We were told the aim was for key workers to review care plans monthly. This was not the case in those we reviewed; we saw updates were made on a more ad hoc basis. It had been identified in the service's action plan for all risk assessments to be reviewed in December 2021 with a deadline of 30 April 2022, but this action was assigned to a staff member who had

left the service.
• Each person's care and support plan included ways to avoid or minimise the need for restricting their freedom. A person who was able to self-propel in their wheelchair, did so with staff present to guide them rather than pushing it.

Staffing and recruitment
• The service did not always have enough staff. The registered manager, team leader and chef had all left recently. The new manager was receiving support from the regional operations director, but a decision had been made not to replace the team leader. Instead, a concierge had been recruited. This role included leading on wellbeing and activities, and administration for new policy implementation throughout the pandemic, while the nurse was expected to manage the shift. We were not assured this structure allowed for full oversight of the home. Following the inspection, we were told that the service had revised this decision and were recruiting a team leader.
• The service struggled to replace the chef, meaning care staff were preparing all meals. Whilst domestic staff were included on the rota, care staff picked up their work when they had left for the day. The staffing calculator used did not evidence how these additional duties had been considered within the care hours. Families told us, "The most experienced members of staff are in the kitchen preparing meals, cooking and cleaning." One relative told us, "Staff are fighting fires and do not have quality time for the residents." Following the inspection, we were told a chef had been recruited. There was also an agency chef, giving further assurance care staff would not be cooking.
• Staff shortage meant personal care needs were not always met in a timely way. On our second visit, a family told us their relative had not showered before they arrived at 11am, which they felt was too late. Other families told us, "Personal hygiene needs to be looked at. Showering and bathing needs to be more regular." Managers reviewed this concern following the inspection. They found personal care was completed daily but at varying times throughout the day.
• We were told staffing issues made it difficult for new starters to get to know people's complex needs. Families said, "Due to lack of staff there is no one to train/go through this with the newer members of staff". However, during the inspection we spoke to a new member of staff who was able to give examples of things people liked to do and the manager told us the rota was being reviewed to ensure there were two of the more experienced staff on each shift.

Sufficient numbers of suitably competent and skilled staff were not available to meet people's needs. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• Despite these concerns, we also observed that there was always one staff member in the lounge/diner, and they told each other when they were leaving. This was in case someone had a seizure in which case there was a button to press to request the assistance of other staff.
• Some people had been provided with one to one care and on occasion two to one care. We observed during our inspection two to one support provided felt excessive for a person settled drawing. The managers informed us this was currently under review. They were meeting with other professionals to find a more holistic approach to arrange the staffing when this level of support was required.
• Staff recruitment promoted safety, including for agency staff. Each person had an 'all about me' document which gave a detailed but concise overview with essential information.

Using medicines safely
• Medicines were not always stored appropriately. The trolley was usually kept in the office but sometimes in the sensory room during the day. A lockable cupboard in a person's room containing non-prescribed medication had been left open. There was also a locked cupboard in the sensory room with medication

stock kept without temperature checks. However, there were plans for a specific medication room and following our inspection we saw evidence that this had been completed.
• Staff administering medicines were not always able to carry out their duties without being disturbed. Whilst the provider's policy stated a medication tabard was to be worn by staff when administering medication to ensure others knew they were not to be disturbed, these were not worn by staff during our site visits. A healthcare professional told us they telephoned the service and it was answered by someone completing the medication round.
• People were supported by staff who followed systems and processes to prescribe, administer and record medicines safely. This included where there were difficulties in communicating and when medicines were given covertly.
• Staff reviewed each person's medicines regularly to monitor the effects on their health and wellbeing and provided advice to people and carers about their medicines.
• PRN is medication prescribed to be given as and when required; the service monitored this well. For example, one person was having pain relief almost daily so the GP was asked to review to find out whether it should be changed to prescribed daily.
• The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles We saw an example where staff had observed a person become distressed and referred to the ABC chart before deciding to administer PRN medication.

Preventing and controlling infection
• We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service employed part time cleaners and whilst the home appeared clean, there was a lot of clutter in some rooms and no records of cleaning had been completed. We were told people's rooms were cleaned daily, but relatives told us, "Rooms need to be properly cleaned regularly, as all the clients have health issues the dust and dirt often in the rooms is not doing them any good."
• We were somewhat assured that the provider was preventing visitors from catching and spreading infections. COVID-19 checks for visitors included temperature checks and an electronic questionnaire. However, this was very slow and completed on a shared touch screen on our first visit but on the second visit staff completed it.
• We were somewhat assured that the provider was meeting shielding and social distancing rules. This was difficult to manage given the support needs of the service users and communal space limitations.
• We were somewhat assured that the provider was using PPE effectively and safely. A relative told us, "All wear masks and aprons. Had to take LFT and show them the pictures and test again on site with temperature check." However, we observed an occasion where staff did not finish washing their hands before passing the nurse a paper towel to wipe a person's mouth.
• We were assured that the provider was accessing testing for people using the service and staff. Staff had weekly PCR and daily LFT tests; service users were tested monthly.
• We were assured that the provider's infection prevention and control policy was up to date.
• We were assured that the provider was admitting people safely to the service. The service ensured service users had been tested for COVID-19 by the hospital before being discharged back to their care.
• We were assured that the provider was making sure infection outbreaks could be effectively prevented or managed.
• The service supported visits for people living in the home in line with current guidance.

Systems and processes to safeguard people from the risk of abuse
• People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse. The service worked well with other agencies to do so.

• Staff had training on how to recognise and report abuse and they knew how to apply it. Staff told us they would escalate concerns to the manager, who would do the safeguarding referral.

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 the last inspection under the previous provider this key question was rated as good. At this inspection this key question has now deteriorated 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
• Assessments were not always updated in a timely way and some relatives told us they had "Not had any recent care reviews." However, we found no impact on people. Assessments were personalised and included peoples physical and mental health needs and how they should be supported including their communication and sensory needs. Some had evidence of family involvement.
• Staff completed functional assessments for people who needed them and took the time to understand people's behaviours.
• People's goals were recorded in care plans. However, some lacked evidence of progression. For example, some care plans identified a risk of social isolation and included steps to prevent these, but lack of staff time and communal space meant goals were not met.

Staff support: induction, training, skills and experience
• The service did not always check staff's competency to ensure they understood and applied training and best practice. Some of the people were on specific diets for texture of foods and thickness of drinks. Care staff told us they did not feel confident they were preparing the meals safely. One staff member said, "We had done our food hygiene training, but I am not happy to cook for these guys. There is different levels of purees. I have not done any training around this. What if something goes wrong." However, we also found some evidence recent food training had been effective. We were shown the app used by care workers where they could record what drinks and food had been offered and what was taken. There was room for notes to be added and staff gave an example, "(person) fussy so we put a note where we have tried with different things, like adding mayonnaise to a meal."
• People were not always supported by staff who had received relevant training. We identified occasions where there were staff working without moving and handling training.

Staff did not receive appropriate training and competency checks to ensure they were able to provide care safely. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• Staff received support in the form of continual supervision, appraisal and recognition of good practice. We saw staff were given positive feedback, able to raise concerns, and additional training or support needs were identified. There were regular supervisions plus 'ad-hoc' ones held for specific issues. There were also some group supervisions.

Supporting people to eat and drink enough to maintain a balanced diet
• People did not always receive support to eat and drink enough to maintain a balanced diet. Some relatives were concerned about the quality, amount and/or variety of the food. Comments included, "There is not enough vegetables in the meals." And, "I do not think they feed her enough…I buy the milk shakes for [them]." And, "Five nights in a row (person) had tomato soup with bread and butter…Often having soup, not varied enough." However, the provider shared food charts covering February and March 2022 which suggested the meals were more varied and another relative said, "nutrition and diet is good".
• People did not always receive food that had been prepared to the required texture. Families told us, "The lack of proper kitchen staff is a big concern to us all as we do not think there is a balanced diet, food is repetitive and there have been big lumps in what should be pureed food."
• People with complex needs did not always receive support to eat and drink in a way that met their personal preferences including in line with their cultural preferences and beliefs. Families told us, "Food that is served often looks unappetising. Clients' needs are not taken into account and unsuitable food served – spicy (albeit mild) or acidy food when there is a reflux problem for example."
• Another professional told us they observed a person being fed who did not need to be. However, we observed one person eating independently. Staff confirmed this was fine and they start with a spoon then use their fingers. We also spoke to a member of staff who was confident they knew people's needs and preferences. They told us, "One of our residents are allergic to tomatoes so I did them a separate meal." We saw it and noted it looked nice and included two portions of vegetables.

Adapting service, design, decoration to meet people's needs
• The interior and decoration of the service was not in line with good practice to meet people's sensory needs. There was a lot of clutter in some rooms, including the sensory room which could not be used for this reason. The provider had a learning disability lead who had identified and corrected this previously, but unfortunately it had not been maintained. After the inspection, we saw evidence that the clutter was removed from the sensory room and the specialist equipment was available for use.
• Some aspects of the environment felt institutionalised, with a reception area at the entrance and posters in communal areas. In response to our feedback, the provider had addressed this.
• The physical environment was not adapted to a standard to meet people's needs. There was limited communal space which meant private space was not available for people to spend time with visitors or spend time alone. There were plans to make one of the rooms into a quiet area/lounge and following the inspection we were saw evidence that this had been implemented.
• Most of the people were in the lounge/diner during both our visits, but this was very noisy, and we observed one person return to their room as a result of this. Relatives told us this was often a problem. One relative said, "The lounge is very noisy so (person) stays in their room." There was a specialist screen, but it was in the main lounge next to the TV (with no sound) and the radio was also on.
• The provider had invested in the fabric of the building. However, we found the way the building was being used did not meet good practice guidance.

Reasonable adjustments had not been made to ensure people's care and support was delivered to meet their needs and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• The environment was not well maintained to meet people's sensory and physical needs. People personalised their rooms and were included in decisions relating to the interior decoration and design of their home, but a lot of the walls had marks and some furniture was scuffed. Families told us, "Personal property is not looked after; things go missing or get broken/ripped and are just left." Following the inspection, we were told that decorators and a sensory garden had been arranged.
• There was access to the garden from the lounge and this was encouraged when the weather was nice.

Supporting people to live healthier lives, access healthcare services and support
• People were referred to health care professionals to help them to live healthy lives. We saw in people's records referrals had been made to district nurses and occupational therapy.
• Multi- disciplinary team professionals were involved to improve people's care. There had been input from the SALT team and a palliative care nurse visited regularly.
• People were supported to attend appointments. Families had raised concerns about people's oral hygiene and access to a dentist. Not all people were registered with a dentist, but the manager had arranged this and was trying to book appointments.

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 Act 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 and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• For people the service assessed as lacking mental capacity for certain decisions, a variety of mental capacity assessments were completed. However, some assessments did not detail the decision needing to be made or the actions t staff should take and why the decision was in the persons best interest. For example, there were MCAs completed for breathing. It was not clear what was being assessed.

We recommend the provider consider current guidance on mental capacity assessments and update their practice to ensure the particular decision is clear and that they are only completed when necessary.

• Where people were restricted, the manager had sought the necessary authorisations to deprive people of their liberty.
• For people lacking capacity to make decisions about their medicines, best practice was followed and there were safe processes around medicines being administered covertly. We reviewed a capacity assessment for administering medication covertly and saw involvement from the person's family and GP for the best interest decision. It made it clear that it did not always need to be administered covertly as sometimes the person was compliant.
• Care plans gave guidance on how to best support people to make decisions, for example by giving two things to choose from at a time.

Requires Improvement

# 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 the last inspection under the previous provider this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
• We received mixed feedback from families about people's support with personal care. One relative told us they felt the person appeared neglected. They said, "Once when I visited, [person's] clothes were dirty and they looked like a tramp. I asked, 'where are [person's] clothes and they were all shabby. I went to the wardrobe and took them all out and told staff to get new ones today." However, comments from other relatives included, "Everything is done for [person] and they keep them clean", "[Person] had foot massages before lockdown" and their "nails were painted".
• Some family members told us their relatives were not showered daily. We reviewed this and found some had been missed when a lot of staff were self-isolating due to COVID-19, leaving the service short staffed. These were exceptional circumstances. However, we were also told showers did not occur until quite late in the day at times and visitors were kept waiting. We raised this with managers, and they told us while most people were showered in the morning, some people had theirs in the evening as it was their preference but we saw no evidence of these time preferences in the care plans we reviewed.
• Another concern from families related to the laundry. Relatives told us of finding their family member's clothing in other people's rooms and bedding on other people's beds. There were also concerns about the quality of the laundry process. Comments included, "The laundry situation is getting worse, we have all tidied our families' wardrobes and drawers only for stuff to be crammed in just anywhere the next day." And, "Clothing not being separated to colours and whites in the wash so everything looks grubby even after the wash." The provider was aware of this issue, it had been discussed at a staff meeting in February 2022. Following the inspection, they told us a new labelling system had been implemented.
• Staff also shared their frustration, one told us, "When you leave the room it should be tidy... when (former staff member) was here they went around checking everyone and everything was where they should be. Now there is nothing like that being done. Gloves and creams are not put away…this morning one of the sinks had water in it, and another person's curtains were closed."

People's personal care needs were not met in a timely way and their possessions and environment were not well maintained. This was a breach of regulation 10 (privacy and dignity) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• However, our findings during both our visits were that people were well presented and some families gave positive feedback including: "I am pleased with how they look after (person)…staff tidy up (person's) hair and nails…it is a happy atmosphere there with people laughing.
• We saw some staff had developed a good rapport with people they supported. For example, we observed a

member of staff ask a person whether it was ok to wash their face. The member of staff had a kind attitude and made the person laugh.

Ensuring people are well treated and supported; respecting equality and diversity
• The impact of the chef leaving meant there were less staff providing support with activities and the more experienced staff were in the kitchen a lot of the time. This meant there were occasions when people received support from staff who did not know them well.
• Feedback from families included, "They do not do activities with them. The residents are in front of the TV all day." However, we observed some nice interactions between staff and people and found permanent staff knew people well. For example, one staff member explained how a person was usually very happy and if they were unhappy this was a sign they may have an infection. Another relative told us, "Staff are wonderful and so good. [Person] does not know me and they are (person's) family now."
• Staff showed genuine interest in people's well-being and quality of life. We spoke to one member of staff who told us there was no roast dinner because the joint had not been ordered. They said, "They had chicken yesterday so couldn't have it again" this demonstrated they were treating people with respect and cared about what they ate.

Supporting people to express their views and be involved in making decisions about their care
• Care plans gave information on how to communicate with people. However, new staff did not always have time to understand people's individual communication styles and develop a rapport with them.
• People, and those important to them, took part in making decisions and planning of their care and risk assessments. We saw evidence of this in people's care plans. However, it was unclear whether involvement was ongoing as some families told us they could not remember any recent care reviews.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection under the previous provider this key question was rated as good. At this inspection this key question has now deteriorated to 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

• The service did not always meet people's individual needs in relation to maintaining interests and hobbies. Staffing issues meant there was not enough time for people to be supported with their activities or they were supported by staff who did not know them well enough to provide appropriate support. The limitations of the physical environment also had an impact on staff's ability to support people with activities. Some of this was addressed after the inspection; the sensory room had been made available for use and a separate quiet area was created. During our inspection, people had not been able to go out as regularly as they would like due to modifications being made to the minibus. Following our inspection, we were told this had been completed and staff were supporting people to go out three times per week.

• New staff were not well-supported to understand and meet the needs of people through learning and development. Families told us, "Some staff are not engaging with clients…when some staff are doing personal care they do not even speak to the client, certainly not reassuring for them."

• People, their families and/or carers were not always involved in developing their care, support and treatment plans. People's needs were identified, including needs on the grounds of protected equality characteristics. However, these were not regularly reviewed, and family involvement was not always ongoing. One relative said, "We had care meetings in the beginning." However, other comments included, "Cannot remember the last care review meeting." And, "…I do not know what is going on."

• Support did not always focus on or monitor people's quality of life outcomes and adapt as a person went through their life. During both our visits there was a lack of involvement in meaningful activities for people. However, the 'Circle of Support' had been introduced in January. This involved people and their relatives/advocates being invited to Multi-disciplinary Team (MDT) meetings twice a year. This demonstrated best practice being implemented but was not fully imbedded yet with only one person taking part so far.

Meeting people's communication needs; 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.

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• Staff did not always ensure people had access to information in formats they could understand. There was an activity board to help people understand what would happen during the day, but this was not being fully used. There was also a menu in picture format which was not being updated.
• People had individual communication plans that detailed effective and preferred methods of communication, including the approach to use for different situations. For example, when offering choice, limit the amount or use pictures. Input from family had been included in care plans to aid effective communication. However, a relative told us, "Staff do not spend enough time talking to residents." They believed their family member's vocabulary and ability to communicate had deteriorated because of this. Another family member had similar concerns, "I get told by other families who visit that if (staff member) is not here and I am not here (person) is sitting on their own."
• When we visited, most people were sitting in front of the TV but did not seem to be watching it. The view was blocked for some and it was muted with subtitles, but the people could not read them. The radio was on as well. However, we also observed someone reading a person's favourite book to them. Another member of staff changed the music to one person's favourite. They seemed to know the people well but were restricted in what they could do in such a small space.
• There was a large specialist screen in the lounge which we observed staff using. Unfortunately, the environment issues had an impact on the effectiveness of what could be a good resource: it was next to the TV and radio and sometimes people would walk in front of it. Following the inspection, the provider told us they had addressed this.

Systems were not used to enable people to understand their care. This was a breach of regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• Some staff had good awareness, skills and understanding of individual communication needs and knew how to facilitate communication and when people were trying to tell them something. For example, we observed a member of staff notice a person distressed and explained this happened when they were hungry or in need of personal care. However, we also observed staff feeding a person who was blind without telling them what the food was.
• Some information had been produced in an easy read format such as the service user guide and safeguarding policy.
• One person had been referred to the clinical lead for assessment, who told us, "I have made recommendations for [person] which would be universal around the house. E.g. Communication aids. I bought a PECS symbol board and I will train the staff." PECS is The Picture Exchange Communication System. It allows people with little or no communication abilities to communicate using pictures.

Improving care quality in response to complaints or concerns
• We were not assured people, and those important to them, could raise concerns and complaints easily and that staff supported them to do so. The complaints log showed the service had received two formal complaints in the last 12 months. Neither of them was raised by people or families via the complaint procedure. One was from a neighbour of the service. One had been identified via the family satisfaction survey relating to the lack of chef. Verbal acknowledgement had been made but initial actions did not address all issues raised. An investigation was to be completed.
• The service did not always treat all concerns and complaints seriously, investigate them and share learning. Family members we spoke with had concerns but had not been told how to make a formal complaint. One told us, "I've been into [a manager] and said I was not happy. I complained once when [another manager] came in and did not get a good response – I complained about the training for new staff and was told 'she is just new'."
• Staff were not committed to supporting people to provide feedback so they could ensure the service worked well for them. The formal complaints log did not reflect all the concerns raised by people about the

service. However, the service user guide did include the complaints procedure in easy-read format.
We recommend the provider seek advice and guidance from a reputable source, about the management of and learning from complaints.
• After the inspection, the provider told us that they sought feedback from people via monthly meetings and the biannual survey and that managers had an 'open door' policy for families to raise concerns. However, we had mixed feedback from families on this, with one saying, "Met the new manager who introduced himself today. I can contact them if I need anything" whilst another did not feel listened to and another said "(manager) is always in meetings when I call or visit".
End of life care and support
• No people were reported to be on end of life care at the time of this inspection. There was a palliative care nurse who visited to support with people's ongoing complex health needs. One relative told us, "Palliative nurse will come once a month and come when needed."
• There was limited information in the care plans we reviewed relating to people's end of life wishes. However, there were bereavement packs which could be given to families if a person died and we saw some examples of funeral plans.

We recommend the provider seek advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their end of life care.

Requires Improvement

# 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 the last inspection under the previous provider this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

• Governance processes were not always effective to keep people safe, protect people's rights and provide good quality care and support. There were systems to monitor the service, but they had failed to pick up the concerns we found.

• Changes had been made to the staffing structure; there was no longer a team leader and additional responsibilities had been distributed to care staff. We were not assured all were being completed efficiently or that it was clear who was responsible for what. Following our inspection, the staffing structure had been revised and a team leader was being recruited to support the manager.

• When the chef left risks relating to both the training need for meal preparation and the impact of taking on additional duties on care staffing levels had not been identified. We were told the nurse in charge was expected to have full oversight of the shift, but we were not assured this was realistic. Following our inspection, we were told the timing of the medication round had been amended to allow the nurse in charge to have oversight of meals.

• Care staff were required to review people's care and support on an ongoing basis as their needs and wishes changed. We were told the aim was for these to be done monthly but we found this was not always the case. We followed this up with managers and were told care evaluation documents were completed separately but we saw no evidence of this.

• The provider gave staff training to meet the needs of all individuals using the service, but the effectiveness of training was not always followed up through observations to assess staff competency.

Systems and processes to assess, monitor and improve the quality and safety of the services provided were not always effective. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• There was a new manager applying for the registered manager position who had the skills, knowledge and experience to perform their role. They did not yet have a clear understanding of people's needs or oversight of the services they managed but felt well supported by both their managers and staff during their induction to the service.

• Staff knew and understood the provider's vision and values and how to apply them in the work of their team. This was a standard agenda item at team meetings to remind staff. We saw ideas taken from their other homes were suggested.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Management were visible in the service, but not always approachable. We were told senior members of the leadership team would visit the home, but staff did not always feel respected, supported and valued by them. We were told they were often too busy or gave negative responses. Staff said, "[They] cannot speak to people nicely."
• Staff did not always raise concerns with managers; they told us of some incidents in the home that the managers were not aware of. After the inspection, we were told staff had received additional training on whistle blowing and posters to encourage people to speak openly had been put up.
• Managers aimed to set a culture that valued reflection, learning and improvement and they were receptive to challenge. After the inspection we were told by managers they were building trust with staff, spending more time in the lounge rather than the office. More staff meetings had been held and additional processes added to improve communication. They felt confident incidents would be reported in future.
• Some families were not happy with the service. However, some were positive about the new manager. One acknowledged, "New manager taken over and will take him time to get to know the residents." Another said, "New manager is still settling in."
• Managers promoted equality and diversity in all aspects of the running of the service. Care plans prompted staff to consider people's gender preferences and staff were recruited from a variety of backgrounds.
• Staff put people's needs and wishes at the heart of everything they did. We found a genuine concern among staff for people. They were concerned about whether the food they were preparing was safe for people and that their time in the kitchen led to people being cared for by staff less familiar with their needs. We observed them offering guidance to other staff.

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
• Minutes of staff meetings showed these were held regularly with standard agenda items to prompt discussion. They showed information was being shared with staff and their views were sought. However, some staff told us there had not been any recent team meetings, so we were not assured the information had been shared with those unable to attend.
• People, and those important to them, worked with managers and staff to develop and improve the service. Some families told us they were unhappy with the response from the service to concerns they had raised. Following our inspection, a meeting had been held with the families and the senior management team and the service shared some positive feedback. They told us, "A lot of what we had discussed before meeting has been sorted out too, certainly feel more positive now, thank you."
• The provider sought feedback from people and those important to them via an annual survey and used the feedback to develop the service.
• A monthly newsletter had been produced to share information with people, relatives and staff. It included updates to staff changes.

Continuous learning and improving care; Working in partnership with others
• Managers were responsive to our findings. Following our inspection, some of the improvements needed had been made and they continued to work towards addressing all our findings. Further time was needed to embed the changes made and ensure processes identified, managed and mitigated any risk to the quality of care provided.
• People's records showed the service worked with health professionals. Referrals for other services such as district nurses, occupational therapists or speech and language therapists were made as required. A family member told us, "OT gave them a new wheelchair to help to take [person] out in the minibus."

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 | Reasonable adjustments had not been made to ensure people's care and support was delivered to meet their needs and preferences and systems were not used to enable people to understand their care. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect |
| Treatment of disease, disorder or injury | People's personal care needs were not met in a timely way and their possessions and environment were not well maintained. |

| 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 | Systems were not robust enough to ensure that peoples current risks were safely managed and mitigated, and accidents and incidents were not always reported. |

| 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 | Systems and processes to assess, monitor and improve the quality and safety of the services provided were not always effective. |

| Regulated activity | Regulation |
|---|---|

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

Sufficient numbers of suitably competent and skilled staff were not available to meet people's needs. Staff did not receive appropriate training and competency checks to ensure they were able to provide care safely.