Alternative Futures Group Limited

Naylorsfield and Hartsbourne

Inspection report

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Date of inspection visit:
10 January 2024
15 January 2024
18 January 2024

Date of publication:
21 March 2024

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
Naylorsfield and Hartsbourne is a residential care home providing personal and nursing care for up to eight people with learning disabilities, mental health and complex care needs. Five people lived in the home at the time of the inspection.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to their community that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Within the areas looked at during this focused inspection; the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.
Right Support: People at times did not receive safe care. Not all risks had been assessed and there were gaps within risk management plans for people. When incidents occurred it was not always clear if actions taken by the provider were done so in alignment with the MCA

The physical layout of the building was not homely or domestic in style. It was clear from the roadside people were living within a care setting.

Parts of the service home were unclean, unhygienic, and poorly maintained in particular within people's bedrooms. Essential improvements were required to the service to make it more homely and fit for purpose. For example, the ovens had not been working properly for some time within one bungalow and within the other bungalow not working at all.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People experienced restrictions in terms of access to food and window restrictions which were not based on people's individual risk. People spent time sitting around with nothing to do. They were not supported to take part in household chores such as cooking or washing and care plans lacked information on how to increase people's independence. The provider had not supported people to take part in activities and pursue their interests in their local area.

Right Care: Staff were kind and respectful in their approach towards people and were knowledgeable about their day-to-day preferences. People were comfortable with staff members; one person told us, "The staff are nice". Staff cared about the people they supported but were frustrated by their inability to deliver person centred care because of financial restrictions which had resulted in people spending large amounts of monies on food in the community which had impacted on their daily routines not being following for some

time. This had not been reviewed by the provider or reported to the local authority.

Right Culture: The provider failed to act in a timely manner to ensure everyone within the service had a safe clean environment that promoted their privacy and dignity.

The service was not using governance processes effectively to learn lessons or improve the service. Governance systems did not ensure people were kept safe and received a high quality of care and support in line with their personal needs.

The service was not able to demonstrate they were meeting the underpinning principles of right support, right care, right culture. Staff lacked knowledge of the right support, right care, right culture guidance.

Management oversight was ineffective, and although systems were in place to monitor the quality of care provided by the service, we found concerns their systems had not effectively identified concerns found during the inspection.

The systems in place to audit the quality of the service were not robust or sufficient to alert the provider of the concerns and issues within the service. Audits had not picked up areas which were identified during the inspection. Accidents and incidents were recorded but not monitored to identify how the risks of reoccurrence could be minimised in future. The provider had failed to notify the Care Quality Commission of all reportable incidents as required. Providers are required to notify the CQC of certain incidents without delay.

There was a lack of provider and managerial oversight of the service. There was a failure by the provider to ensure robust governance arrangements were in place to monitor the safety and quality of the service. Shortfalls across the service such as poor risk management, IPC concerns and restrictions to people's daily living had not been identified prior to our inspection.

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

Rating at last inspection and update
The last rating for this service was good (published 7 April 2020).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

The inspection was prompted in part due to concerns received about the service in terms of restrictions. A decision was made for us to inspect and examine those risks. As a result, we carried out a focused inspection to review the key questions of safe, effective, caring, responsive and well-led.

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.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this report.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

Enforcement and Recommendations
At this inspection we have identified breaches in relation to safe care and treatment, person-centred care and the assessment of risks, management's response to safeguarding concerns, restrictive practices and the application of the mental capacity act, maintaining a safe environment and effective governance of the service.

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

The overall rating for this service is 'Inadequate' and the service is 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 take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Naylorsfield and Hartsbourne

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.

Inspection team
This inspection was carried out by 2 inspectors and an 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
Naylorsfield and Hartsbourne is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service had a manager registered with the Care Quality Commission. 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.

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
We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed

to be sure that the provider or registered manager would be in the office to support the inspection.

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

During the inspection
We spoke with 5 people who used the service about their experience of the care provided. We spoke with 11 members of staff including the registered manager, quality lead, team leaders, registered nurse and support workers. We walked around the building to check if the service was clean, hygienic and a safe place for people to live.
We reviewed a range of records. This included people's care records and medication records. We looked at 5 support plans, 2 staff files in relation to recruitment and a variety of records relating to the management of the service, including policies and procedures.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. 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; learning lessons when things go wrong

- The provider did not ensure risks were assessed and managed. Some records reflected detailed risk management plans based on an initial assessment whilst others presented gaps and a lack or risk management for specific risks.
- There was a lack of robust risk management to prevent further incidents and it was unclear within support plans and daily care notes how risks should be managed.
- Restrictions were placed upon a person following a serious incident and although a risk assessment and risk management plan was completed this had not been followed to ensure the safety of others. A known risk for another person had not been assessed or appropriately managed placing the person and others at risk of harm.
- Window restrictors had been fitted to all windows in both bungalows following an incident in November 2023. However, the provider failed to follow the Mental Capacity Act (MCA) code of practice to ensure this practice was lawful and in people's best interest. In addition, no consideration had been given to assessing the risk the window restrictors posed in the event of an evacuation.
- There was a lack of effective processes and leadership at the service to ensure concerns were fully addressed and lessons were learnt.
- The provider's system and processes for managing incidents and accidents was not robust. Incident records lacked detail of these occurrences and no analysis was completed to show what immediate action was taken to keep people safe and for future learning.

The provider failed to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Safety checks took place on the environment, including electrical and gas services.

Systems and processes to safeguard people from the risk of abuse

- We observed multiple examples of institutionalised practice, such as, restrictions, and the displaying of signs on walls and doors throughout both bungalows with instructions and guidance for staff on working practices.
- People's access to food and cooking equipment had been restricted for some time. There was overwhelming evidence documented in people's care records and through discussions with people showing they had purchased meals, snacks and drinks from local supermarkets and fast-food outlets using their own personal money. This resulted in a financial cost to people and impacted on their ability to live their chosen lifestyle. A safeguarding referral was reported to the local authority during the inspection to review this concern.

● Staff had received safeguarding training; however, records showed the training had expired for some staff.

The provider failed to fully protect people from the risk of abuse or improper treatment as safeguarding systems and processes were not effectively operated. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager and provider were receptive to our feedback and addressed some issues quickly such as the issues with access to food, window restrictors and staff use of lanyards and keys.

Preventing and controlling infection

●People were not protected from the risk of infection as staff were not following safe infection prevention and control (IPC) practices. Parts of the service in particular people's bedrooms were visibly unclean, unhygienic, and poorly maintained.

● One person's bedroom had food which had passed its use by date by several weeks and items of mouldy food. Two people's bedrooms were littered with empty food and drink packaging and there was mould on their window frames and floors in two people's bedrooms.

● There were inadequate supplies of clean bedding held at the service and some people's bed sheets, duvets and pillows were visibly stained and unhygienic.

● Many items of furniture in communal areas including sofas were damaged making effective cleaning difficult.

The provider had failed to ensure that all areas of the home were clean, hygienic and were effective in helping to prevent the spread of any infections. This is a breach of regulation 12 (Safe Care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were good supplies of PPE at the home and staff made appropriate use of it.

Using medicines safely

● The provider did not always ensure medicines were managed in a safe way.

● Medicines were not stored safely as the room temperature exceeded the recommended maximum room temperature required to ensure medicines remained effective. Records showed this had been a regular occurrence, however no action was taken.

● Not all protocols for people who required medicines on an 'as required' basis were in place.

● Records showed training was out of date or not completed for some staff with responsibilities for medicine management.

The storage of medication was unsafe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff were safely recruited. Appropriate checks had been made before being offered employment.

● There were sufficient numbers of staff deployed at the service to meet people's needs.

● A copy of the service user guide was provided; this highlighted a key worker system for people living within the service. At the time of the inspection, there was no key worker system in place matched to people's needs and requirements.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question outstanding. 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.

Supporting people to eat and drink enough to maintain a balanced diet; supporting people to live healthier lives, access healthcare services and support

- People did not have access to a variety of food and drink to meet their nutritional needs.
- Food stocks held in both bungalows were minimal. The fridge in bungalow 2 was empty and there were few food items in kitchen cupboards.
- Main meals for all people living at the service were cooked in bungalow 1 and transported to bungalow 2 for the people living there. People had no free access to food items should they want a snack in between main meals.
- People's support plans lacked information about their nutritional and hydration needs and how they were to be met.
- Staff had compiled a weekly menu for main meals; however, it was displayed on the wall in the locked office out of sight of people.
- Some people's support plans stated they were to be involved in shopping for food and food planning and preparation, however there was no evidence that this was taking place.

The provider failed to ensure people's nutrition and hydration needs were assessed and planned for and that they had access to a variety of suitable and nutritious food. This is a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Records confirmed people were supported to access healthcare services including their GP and other primary healthcare services.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider failed to work within the requirements of the MCA when imposing restrictions upon people.
● Restrictions placed upon people included the fitting of window restrictors across both bungalows and restricted access to food. There was no evidence that people or others acting on their behalf were consulted or involved in these restrictions or that they were made in people's best interest.

The provider failed to ensure consent was obtained from people in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager and provider were receptive to our feedback and the window restrictors were removed on day 1 of the inspection.

Adapting service, design, decoration to meet people's needs; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Parts of the environment was not adapted, designed or decorated to meet people's needs.
● The environment did not appear homely and inviting. There was limited furniture within communal areas and no curtains fitted to the windows.
● Some items of furniture were in a poor state of repair and stained or ripped to certain areas.
● Equipment and broken items took prolonged periods to replace. For example, the ovens in both bungalows were not working and had been faulty for some time. Following our feedback on day 1 of the inspection air fryers were purchased as a temporary measure and were in place by day 2 of the inspection.

Staff support: induction, training, skills and experience
● Staff files observed evidenced safe recruitment processes had been followed.
● New staff completed induction training and there was an ongoing programme of training relevant to staff roles and responsibilities.
● Staff completed classroom based and online training. However, the training matrix highlighted topics of training and competency assessments for some staff had expired including medication, choking risk and basic life support.

We recommend the provider review the training courses provided to ensure they provide staff with the qualifications and skills needed to effectively support people with a learning disability.

Staff working with other agencies to provide consistent, effective, timely care
● People's health conditions were managed appropriately, and staff engaged with external healthcare professionals for example GP's, social workers and speech and language therapists.
● Each person had a health care plan called, 'My Health Passport' which detailed people's healthcare needs.
● Feedback from a registered mental health nurse was positive regarding the service. They told us, "Compassionate care advocating for staff and service users."

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported, respecting equality and diversity

- People were not always well-supported due to institutional practices in the service. Some people's bedrooms were visibly untidy and unclean. A member of staff told us people were responsible for keeping their own rooms clean and tidy, this was despite people's support plans stating they required full staff support with these tasks.
- Some staff showed a lack of dignity and respect towards people in their own home. For example, whilst on shift staff wore their coats and hats and used their personal mobile phones. Staff also wore lanyards holding their ID badges and lanyards holding bunches of keys.
- One person who used the service was supported by 3 staff when accessing the community and had requested a lanyard to wear when out in the community with staff. The person requested this as they did not want to be singled out as a person receiving care. Staff had been told not to allow this.

The provider failed to ensure people were treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

- People's privacy, dignity and independence was not always promoted and respected.
- Some people's beds did not have a headboard, one person said they were not bothered, however they confirmed they had never been offered one since moving in.
- One person had moved from bungalow 1 into bungalow 2 in November 2023. Their clothes and other personal belongings were transferred in bin bags which remained on the floor and unpacked at the time of the inspection.
- A Care Act review for a person referenced their request for a shower to be installed over a bath to enable them to have sole use of the shower. The provider agreed to review this in 2022, however, to date this had not been actioned.
- There was a clear pane of glass above bedrooms and bathrooms which compromised people's privacy. A black bin bag had been taped to the pane of glass above one person's window. The person told us this was done in response to them telling staff they were finding it difficult to sleep at night because of the light coming into their room from the hallway. The person told us the light was still bothering them.
- People's support plans instructed staff on how best to support people to develop their independence, for example around household tasks such as cleaning and tidying their bedrooms. However, it was evident through our observations, discussions with staff and people and through a review of people's records that their independence was not being promoted in line with their support plans.

The provider failed to promote people's privacy, dignity and independence. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Monthly 'empowerment' meetings were held with people who use the service. The minutes evidenced people had the opportunity to feedback any concerns or positive experiences. A recent meeting after our inspection referenced the changes to window restrictors and the purchase of snacks. Feedback was positive from people who used the service and comments included, "Service user was especially happy about this. Shouldn't have been put on anyway".
- One person's relative told us, "Staff are very caring and do a marvellous job."
- A member of staff told us that it was important that they built positive relationships with people they supported and gained their trust.

Requires Improvement

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 good. At this inspection the rating has changed 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; 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

- People did not always receive person centred care to meet their needs, goals and aspirations. The provider did not follow right support, right care, right culture guidance for supporting autistic people and people with a learning disability.
- Some people had weekly activity planners detailing their preferred hobbies and interests, however, they did not always include information about how activities were planned or evaluated.
- Staff told us how they encouraged and supported people to access activities in the community, however one person was unable to pursue their preferred interests and activities in the community due to financial restraints. There was no evidence the person had received support to effectively manage their finances.
- One person's support plan stated it was very important for the person to follow their weekly planner to ensure their mental health remains good. Feedback from the person and from staff members evidenced the weekly planner had not been followed for some time and daily care notes referenced the person spent long periods alone in their bedroom with little interaction from staff.
- Records relating to care and treatment required further improvement to ensure they were accurate and complete. For example, 12- monthly reviews were not always fully completed with gaps on planning for the future and involvement of relevant others such as family members and professional's feedback.

Systems were not in place to ensure people's needs were assessed and planned for in a person-centred way. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Seasonal planned activities took place within the service and people were engaged in planning for these events.
- People were supported to maintain relationships with people important to them.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The provider understood the need for information to be accessible.

● People currently living at the service did not need any adaptations for accessible materials. The registered manager confirmed that documents could be produced in different formats and larger print should they be required.

Improving care quality in response to complaints or concerns

● A complaints policy was in place and information on how to make a complaint was available.

● A complaints log was in place to reference dates, themes, and outcomes of complaints. One complaint received in November 2023 had not been resolved and the complainant had not been updated with regards to progress of the complaint. This did not follow the provider's complaints process and timelines for complaints received to the service. The provider agreed to review this during the inspection.

● A person who used the service raised a complaint in 2023 regarding the use of window restrictors and access to food. These themes were identified during the inspection and the provider was receptive to our feedback and addressed some issues quickly.

● People living in the home told us they could speak with any member of staff should they be worried or have a complaint.

End of life care and support

● At the time of inspection, no-one was receiving end of life support. There was acknowledgement from the management team that people's wishes would be further explored as they got to know them.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. 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

- The registered manager and provider lacked knowledge about right support, right care, right culture guidance and failed to follow the principles.
- There was a lack of robust leadership day to day due to the registered manager having additional management responsibilities for another registered location. Despite working hard, they were often stretched and unable to complete all required governance audits to monitor and assess the quality and safety of the care provided.
- A range of audits had been delegated to the responsibility of team leaders, however there were gaps in the audits and the issues found at the inspection had not been identified.
- The provider demonstrated a poor understanding of the Mental Capacity Act 2005 and its application which had resulted in unlawful restrictions being placed upon people.
- Support plans and associated care records lacked detail about people's needs and how they were to be met and were not subject to regular review to ensure they remained current. As a result, people were exposed to the continued risk of harm and poor care.
- The registered manager and provider had created a management model which did not ensure staff practice, risks, and people's daily life experience was being thoroughly checked and assessed. This put people at risk of experiencing abuse and harm.
- The registered manager and provider had not ensured all important events, such as a serious injury and a safeguarding referral to the local authority, were shared with the CQC in a timely way.

The provider failed to operate effective systems and processes to assess and monitor the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

- The design of people's accommodation, the use of the building and the delivery of people's support did not promote people's dignity, develop their skills, maximise their choice or be as independent as possible. The service did not promote people to enjoy their home in an ordinary and everyday manner.
- There was not always access to cooking and facilities within the kitchen. Records reflected long periods

waiting for replacement items such as washing machines, tumble dryers, and toasters. One of the bungalows did not have a working oven resulting in people unable to cook independently. Daily records evidenced this was not meeting some people's needs and at times had a negative impact on them.

● Some people spent prolonged periods alone in their bedrooms and care notes reflected people's mood had declined and negative experiences with episodes of boredom.

● Systems for continuous learning and improving people's care were not effective. For example, there were a lack of support planning and daily care audits to review people's daily living and any restrictions imposed on them. Opportunities to drive through improvements in people's care were missed or not always taken.

● The provider had not identified or acted to ensure person-centred arrangements and adaptations for people's care and their environment in accordance with their needs. People were not effectively involved or consulted to inform their care and related decision-making in relation to the development of the service.

● The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour providers must be open and transparent if things go wrong with care and treatment. During the inspection we found the management team had not taken appropriate steps to identify and/or act upon the issues identified which meant they were not aware of their responsibilities under the Duty of Candour.

The provider had failed to deliver effective governance systems. This is a breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014.

● Staff spoke positively about how they tried to encourage people to participate in activities and discussed how financial constraints had impacted on people's daily living.

Working in partnership with other

● The service worked with health care professionals such as the speech and language therapy team, the GP, and the registered learning disability nurse and social workers. Compliments had been received to the service from social workers reflecting good partnership working.

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 The provider had failed to provide person centred care for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure consent was obtained from people in accordance with the Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to fully protect people from the risk of abuse or improper treatment as safeguarding systems and processes were not effectively operated

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 14 HSCA RA Regulations 2014 Meeting

personal care

nutritional and hydration needs

The provider had failed to ensure people's nutritional and hydration needs were met.