Community Homes of Intensive Care and Education Limited

Ballards Ash

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Ballard's Ash is a residential care home which is registered to provide a service for up to ten people. People living at Ballards Ash had diagnosed needs including a learning disability, mental health disorders and some people were on the autistic spectrum. At the time of our inspection eight people were living in the home. One person was currently being supported at another of the provider's homes and there was one vacancy.

The service has not developed in line with or consistently applied the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The service is larger than recommended by best practice guidance. There were environmental factors that reduced the likelihood of being able to provide complete person centred care and maximise independence, choice, control and involvement in the community.

People's experience of using this service and what we found
The risk of harm to people and staff had not been safely or effectively assessed and mitigated. There were people whose behaviours at times placed them, the staff and others at risk of harm. We had some concerns and observed that staff's approach to people's needs was not consistent, or always in line with people's care plans. There was a failure to review methods, amend measures and support staff to learn and develop their responses to keep people safe. Staff told us they felt a high staff turnover impacted their ability to support people well due to people displaying high levels of aggressive behaviour. The systems in place would not have prevented an infection from spreading and increased the risk of exposure for people.

The culture within the service did not promote a positive environment for the people living there or the staff who supported them. Staff told us they felt worn down and there was a lack of proactive actions taken to improve outcomes for people. Staff gave mixed feedback about the support they received from the registered manager. Prior to this inspection there had been allegations that documentary evidence was being falsified and backdated. From our inspection this was in part substantiated. People in the home had the opportunity to attend service user meetings and provide feedback through a survey. Some professionals expressed concerns that implementation of advice was inconsistent.

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 this service was Good (published 27 December 2017).

Why we inspected
The inspection was prompted in part due to safeguarding and whistleblowing concerns received about increased incidents of physical abuse between people in the service, lack of management support, incomplete or back dated documentation and a lack of suitable staffing levels. The Local Authority are currently reviewing some safeguarding's that have been made about this service. As a result, we undertook a

focused inspection to review the key questions of safe and well led only. We did not inspect the other key questions at this time. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We have found evidence that the provider needs to make improvements. The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ballards Ash on our website at www.cqc.org.uk.

Enforcement
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. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
The provider has shared details of their action plan to address the concerns raised. The provider has assured us they will not be accepting any new placements at this time whilst they focus on improving the service. We have had a meeting with this provider to discuss our concerns and how they will implement change and improvements. We will work with the local authority to monitor progress and continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below

Ballards Ash

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.

Inspection team
The inspection team consisted of two inspectors.

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

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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spent time observing people in their home environment, some people had limited speech or communicated through signing, expressions or tone. We received feedback from four relatives about their

experience of the care provided. We spoke with 14 members of staff including the registered manager, deputy manager, senior care staff and care workers.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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 and gained feedback from five professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● People may not be kept safe as not all staff were clear on the action they would take in event of identifying a concern. Staff gave mixed responses including, "I would look for bruises and marks, physical signs, are they withdrawn, spending time on their own, or don't want to be near people", "It would depend on what kind of thing it was, I would try and deal with it myself, I would raise it too of course" and "There is a whistleblowing number for Choice Care, if needed contact the local council" (Whistleblowing is the process by which workers can report certain types of wrongdoing, and are protected from unfair treatment in their decision to report events). Another staff told us they had not heard of whistleblowing before but would go to their manager if concerned. Most family members we spoke with felt their relative was safe.

● We observed and staff told us that not everyone was supported in a consistent way. Supporting people in a consistent way may help to reduce anxieties and uncertainty. One staff told us, "I worry about bad habits and consistency towards people, everything I do is picked up from others as seen it's worked and try it but no one checks. Not everyone has the same approach, it's not really checked or watched." During our inspection we observed one staff member raise their voice and shout at a person when they became distressed by another person being hit. A second staff member had to explain to that staff why that person had become upset which then calmed the situation. One staff member told us, "I think that not everyone adheres to the same level of patience or consideration here, if I thought it caused distress I would be more concerned but it's about following the person centred approaches we have been told."

● We saw that this inconsistent approach had also been discussed with staff in their supervisions. Discussions had been held around staff needing to keep calm, have control over their own emotions and attitudes and improve on how they responded to people's behaviours. There was also conversations around a lack of respect shown for people's belongings and bedrooms. Although the discussions had been held, there was not a clear plan and timeframe for solutions to this.

● We have continued to receive concerning information from whistle-blowers and information was shared to us from the safeguarding team. Another safeguarding is currently in progress with allegations made that the service failed to act in a timely manner to support a person before their health significantly deteriorated, resulting in a long period of hospitalisation. The provider has and is investigating these concerns as they are reported.

Failing to ensure staff were supported to safely manage and meet people's needs increased the risk of harm for people. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After this inspection the provider informed us that they had conducted follow up interviews with staff, to ensure they understood their role and responsibilities in identifying and reporting on safeguarding concerns.

Assessing risk, safety monitoring and management

● Some of the people living in the service had very complex behaviours and at times this resulted in physical aggression shown towards other people and staff. The management of these types of behaviours was not always safe or effective.

● People had risk assessments in place to manage behaviours that may cause harm to themselves or others. These contained good detail however staff confirmed they did not always have the time to read these and strategies from professional input were not always followed or reviewed. Behaviours documented from people included, hitting, punching, biting, knocking items over, headbutting and self-injurious behaviours. One staff told us, "There's not enough time to do training. They ask you to look at all the notes of people, but you can't do this when you are caring for people. You struggle to do everything properly."

● We saw one person often reacted in a physical manner when staff prevented them from having a snack. The reasons given by staff were recorded as the person had just eaten breakfast. On one occasion the person had requested a piece of fruit and was told by staff they were not allowed which then led to the person becoming frustrated and aggressive. Following our inspection the provider told us they were reviewing this person's support plan and the responses from staff.

● There were some behaviour episodes recorded and graded with how severe the behaviour was. At times the original number had been crossed out and in a different pen had been marked down. There was no explanation given as to why this had been done. We saw one incident had resulted in a staff member 'grabbing' the person's forearm for two minutes but this was graded low. The provider informed us following this inspection that the terminology of 'grabbing' was incorrect and should not have been used and would be discussed with the staff member concerned.

● Staff told us they felt a high staff turnover impacted their ability to support people's behaviour needs well. Staff commented, "We have quite a big staff turn-over, we are always getting new staff, we have some staff who think they know better, it's not I'm not going to do the support plan, but sometimes it's not followed as it should be. They have different opinions and they think their opinion is more important", "Investigations from a paperwork view are completed and staff will say how they are doing but it can vary. From what have I seen we don't do enough proactive prevention for any of our service users and this causes me a lot of stress with a lack of support and overall structure" and "I feel confident in situations of behaviour, we are all trained. I don't think the individuals have enough staff to them, everyone here should be one to one. There would be less incidents if people have this."

● The lunchtime period was not always managed effectively to reduce people's anxiety levels. The kitchen door was located along a narrow corridor and this area was congested with people walking and congregating in this space. Lunch was served 45 minutes late, which staff said was because they did not have all the necessary ingredients. This was a heightened time for one person as it triggered their anxiety levels and often resulted in physically aggressive behaviours. We saw this person was supported by five different members of staff during 45 minutes who swapped with each other as they went to undertake different tasks. The staff approaches varied each time. There was a variety of mixed styles from talking, trying to lead the person away, standing at the kitchen door alongside them holding their hands, using Makaton to attempt to engage and offering an activity. One staff inside of the kitchen was heard to say, "dinner is not ready, you can shout but it's not ready." The door was then shut in front of this person.

● The approach taken by staff conflicted with the support detailed in this person's care plan. For example, it stated that "[person] appears to work best with female members of staff." Although female staff were on duty three male staff took over the support during this time. The provider has informed us this care plan has now been updated to show this person's preferences clearly.

● There was contradiction shown from staff in allowing this person to enter the kitchen. Four staff were observed restricting this person by blocking their entrance and telling the person no and the fifth person took them into the kitchen saying, "I'm going to take [person] in the kitchen and find out what's going on as this isn't right." The care plan indicated that it helped to not repeatedly open the kitchen door, staff however

frequently entered and exited the kitchen squeezing past this person to prevent their entry and putting their body in between the kitchen and the person.
● During this time attempts were made by this person to hit other people. They did eventually hit another person causing the situation to increase in anxiety. Staff were trying to prevent this situation by getting in between people and asking other's to refrain from walking past and restricting their movements. The provider had recently put in one to one staffing for this person to try and reduce their behaviour incidents to others. This decision was taken following a lengthy dispute with the funding authority over this person's supported hours.
● Staff had completed training around behaviour management and intervention strategies. The registered manager told us, "I am aware we need further self-harm training, this is pending the behaviour team being able to come in, we do already have additional intensive interaction training booked and some of the other courses on this can be delivered online but self-harm is face to face." As an interim measure staff who had already received the training were being allocated to support this person. One staff told us ,"The training at Ballards touches the surface but doesn't go into anything deeply. It's very basic. They seem to be pushing you through courses to get it done rather than the quality. It's not as detailed as I thought it would be for people who can't communicate with you."
● One person needed support with an aspect of their personal hygiene. This required regular support and intervention from staff. The records indicated that the checks were not happening as frequently as they should particularly at night. On at least five occasions in June, records indicated care was not provided for over eight hours, the longest gap being 10 hours. The registered manager told us that documentation training was to be completed with all staff and that most staff had received specific training but some were outstanding due to the specialist nurse being unable to visit due to the COVID 19 pandemic risks. The lack of timely intervention and support from staff could impact on the persons comfort, dignity and self esteem.

There was a failure to take appropriate measures to mitigate risks and ensure people received safe care and treatment. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Staff told us that there was little opportunity for reflection or learning from incidents, saying "You aren't allowed to talk too much about [medicine errors]- some staff will say they can't administer but they can't tell you why, it's quite hush hush, you just have to infer that you can't" and "We have quite a few safeguarding incidents, if it happens, we have to fill out paperwork, we don't really get any feedback on what went wrong or how we can change. We are told to stop it from happening but we are not told how."
● The service had made referrals to external professionals and communicated with them about supporting people's behaviour needs. The registered manger told us there was analysis of trends completed, however, there was a lack of documented evidence of how this changed things at a service level in order to assist practice and improve outcomes for people.
● There was an acceptance in how staff viewed violence and self-harm, as something that was unavoidable and normalised it as part of their role. Staff did not receive a debrief or the chance to discuss their feelings and approach of incidents for a wider group reflection. One staff told us, "I was taken by surprise and received my first physical injury and I wasn't warned. I didn't get any support for this, it was implied it was part of the job. Staff showed disregard for it and it was no big deal and others showed a lot of support and said I shouldn't be in this position. I put this down to a lack of managerial focus and it's like headless chickens." Other staff commented, "You sort of get used to it, I used to get bitten by [person] all the time, they are not really trying to injure you, everyone has a bad day, you take the good with the bad", "The staff are great and they have tales to tell and incidents to share, I just find it's about getting by and doing what you can with what you have got" and "You get hit quite regularly, but they are never going to knock you out,

we use SCIP (Strategies for Crisis Intervention and Prevention) training if needed but that's a last resort. It's just trying to keep the person safe, obviously we are going to get injuries, but making sure that we keep the service users safe from harm."

There was a failure to review methods, amend measures and support staff to learn and develop their responses to keep people safe. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider sent further evidence of contact with external professionals and informed us they will be reviewing staff responses to people's behaviour and the support needed.

● These concerns have been shared with the senior management team who have informed us they will be implementing an immediate action plan and looking at ways to support the staff and leadership within the home. Since our inspection the behaviour records have been changed to allow a section for reflective practice and these must be signed off by the registered manager. The service is implementing monthly supervisions for staff and senior management will be increasing their presence at this service to be available to talk with staff.

Preventing and controlling infection
● We found that good infection prevention control systems were not always maintained. This was even more relevant in the current pandemic climate.
● The use of PPE (personal protective equipment) worn by staff was inconsistent. We saw that as the day went on the PPE staff wore increased from just a mask to aprons and gloves as well. Staff's understanding on when PPE should be used was not always in line with the information given to us by the registered manager. One staff member confirmed they had been asked to wear more PPE since our visit had commenced. Other staff comments included, "We wear them all the time, within two metres of a service user", "Masks all the time, if I'm honest we weren't being encouraged to wear gloves and aprons - we've been told to wear them all time now" and "You get your mask straight away, they are usually kept by the door. Only masks for handover - we have aprons and gloves scattered around, it can be unorganised, but they are in people's room."
● We observed that some areas of the home appeared unclean and in need of decoration. For example, the downstairs sinks and staff toilet were not suitably clean. Staff told us they did not always have time to change people's bathroom bins and used incontinence pads would cause an unpleasant smell during the day. There were marks and peeling paint in areas. The registered manager told us some people's bathrooms and bedrooms had been newly refurbished and further work was planned but delayed in light of the COVID 19 pandemic.
● There were not sufficient or appropriately located clinical waste bins for staff to dispose of PPE safely. We saw that PPE had been disposed of in non-clinical waste bins and staff had to walk through the building again after disposing of their used PPE.
● Paper towels were not always available for people to observe recommended hand washing procedures. This was not picked up by any staff during our visit until we raised this with the management team who then replenished these.
● We reviewed the cleaning records and saw there were some gaps where cleaning had not been recorded and it was unknown if it had been completed. One staff told us "If the housekeeper is off unwell the cleaning records are not completed but staff maintain it but they don't always sign for it."
● Following our inspection, we made a referral to the health protection team to support the service around these concerns. The registered manager received this support openly and immediately informed us of what they had done to address these infection control issues. This included meeting with staff, placing extra

signage around the home, making a PPE station available and booking further training with Wiltshire council. After our inspection the provider informed us they were addressing our concerns and making the necessary improvements.

Staffing and recruitment

● Staff consistently told us they felt there was not enough staff to meet people's needs effectively. Comments included, "My main issue is there is not enough staff and I have spoken to the manager and she says they can't afford more staff and you either live with it or the home closes", "Absolutely not enough staff. I haven't eaten today and only had drink 30 mins ago as was reminded, we are mentally stressed, need a lot more leadership and staff need time to breathe. Concerns me that staff are worn down", "Staff come and leave after a few months in this home, I don't know the reason, it may be management. This is a concern, there is not enough staff, new staff we can't use as a full staff as not had training but on rota will look like we are fully staffed" and "Sometimes we don't have enough staff and people want attention all the time and because of the people who have the most challenging behaviour we are drawn away to that person and others don't understand. We need more staff."

● During the inspection staff were visible around the service. There was often clusters of people and staff in one area which at times heightened people's behaviour and the noise levels. It was hard to understand the deployment of staff during the shift as staff would regularly switch between themselves on who they were supporting and the roles they undertook. The registered manager confirmed there had been times of high sickness levels and no deputy manager and she had completed a lot of care shifts which impacted on the time spent managing the service.

● There was mixed feedback given about the induction and training staff received to enable them to be effective and skilled in their roles. Staff told us, "Training has been adhoc, in terms of actual support there was a trial by 'fire period' (A case of being thrown in the deep end). Luckily I had lists and spent time talking to other staff about what I had to do. At this point I have picked it up but at the expense of formal training", "We have SCIP training but most of the time it's out of the blue, [person] will hit me on the back when I'm doing my meds, SCIP I've always thought is not most effective thing." One relative told us, "I do not feel that staff are well trained. Whilst some members are very caring, it is clear that there is a lack of training for staff."

● We reviewed the training matrix and saw whilst there were some gaps this had been as a result of restrictions during COVID. Staff had continued to complete training online and some face to face training but some felt this was not sufficient to support the complex behaviours of people in the home.

Using medicines safely

● At this inspection we did not visually observe the administration or storage procedures for medicine. We reviewed documentary evidence relating to the safe management of medicines. Prior to this inspection we had received a notification for a medicine error in which medicine had been administered incorrectly. We saw another medicine error had occurred in May where a person's rescue medicine had not been taken with them when they left the service. The registered manager told us that all errors were investigated and discussed with the individual staff members.

● The registered manager completed monthly medicine audits and senior staff completed weekly medicine checks. We reviewed these from April to June and saw that there was consistent gaps in missing signatures where medicine had not been signed to show administration and errors in medicine stock level checks. The registered manager said these were addressed with staff, however the continued errors demonstrated that the action taken had not been effective in reducing these errors and the safe management of medicines was not maintained.

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 this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The culture within the service did not promote a positive environment for the people living there or the staff who supported them. Some people at this service had complex behaviours that at times manifested in physically aggressive responses. There was a theme of staff feeling worn down and a lack of proactive actions taken to improve outcomes for people in the management and review of behaviour at a practice level.
- Staff gave mixed feedback about the support they received from the registered manager. The majority of staff were not positive and spoke about feeling isolated and undervalued. Comments included, "They [management] are not completely disregarding you can technically approach them. We are not being supported in team meetings, we bring up about quality of life for people and wanting alternatives for people and the response will be make time or you need to do more with them. We need managerial support as there is not time to do paperwork and interactions" and "If you need support for something to do with work, it's listened too but never really acted upon, never a plan saying this is what we are going to do."
- Some staff had reached a place where the job role was impacting negatively on their wellbeing and considerations were being made to seek alternative employment. One staff told us, "I spoke to [registered manager] and it's impacting my mental health, she said there's nothing she can do at the moment as we have new staff and we don't have enough other staff. I don't think that's good enough as having an impact on me. She said I'm not the only one who has raised these concerns." Another staff member said, "I struggle with their style of management it's rubbish. They have no skills for people, they just tell you to do things and it's not a great style. I find it's firefighting, a lot of the management don't support the guys on the ground. If I was a parent I wouldn't send my child there after working here."
- There was a lack of leadership in changing and addressing these concerns in the service. Despite staff raising these concerns directly and in their supervisions there had not been action taken to recognise the negative culture developing and support the staff that were feeling this way. The registered manager told us, "I feel like I have tried to support the team but they are not always happy. The staff feel that they need more staff and I do agree with them but I'm fighting to try and get that for them."
- Prior to this inspection there had been information received and shared with us, that some documentary evidence was being falsified and backdated. From speaking with staff and a review of a cleaning schedule this was in part substantiated.
- Some staff told us there were times where they were asked to backdate documentation or sign for care

tasks they didn't complete. Comments included, "Well, nine out of ten percent [documentation] is written well, sometimes they do get missed, then the management will go through it a week later and say can you fill this in, but I usually say I wasn't even me so I can't fill it in", "I was asked to document on paperwork of other people's initials, I was asked if I could do it to look good for the auditors", "You can get asked to do a lot at once. Under pressure" and "You get records to fill in for people that you haven't given care for or being with and you are not fraudulent, but you are writing things about people that you don't know enough about."

● The registered manager told us hourly cleaning of high touch points was being completed due to the increased risk of COVID 19. During our inspection, we observed this was not always completed. The recording sheet for this had been signed, however the cleaning had been observed to not have taken place.

● Quality assurance systems were in place; however, these did not evidence sustained change or improvements for some areas within the service. The registered manager completed audits in areas including medicines, health and safety and infection control. An internal inspection took place in January 2020 and the service was scored at 88%. The registered manager said monthly visits were made by the regional manager and they would discuss areas to develop.

● Although we saw that gaps in documentation and other issues had been picked up, these continued to be found in the following audits. Actions taken to speak with staff in meetings and supervisions had not promoted a change and further action to identifying the root cause of these issues had not been taken. One staff meeting in April 2020 recorded a staff raising the issue of staff feeling under pressure and that some staff were not adequately trained to support particular individuals. The response given was that they would soon be trained and the staffing levels were safe despite being the minimum. This did not allow for exploring the concerns and feelings of staff or looking at practical ways to arrange the shifts to support staff further.

The provider had failed to effectively evaluate and improve the quality of their practice for people and staff. There was a lack of good governance and oversight within this service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some staff told us they did feel the manager was available and approachable commenting, "Very approachable, would go to her. She is probably one of the most approachable managers I have ever had", "The manager is approachable, she's working very hard, she comes early and goes late. She does every day I don't know how" and "if you have an issue you can go to them, the deputy is still learning the ropes. I think [registered manager] is quite overwhelmed, she's got so much to do, things get lost in communication."

● The majority of relatives we spoke with were happy with the service and praised the care their family member received commenting, "When I visit unexpectedly, the atmosphere is always welcoming and peaceful. Our [relative] has been at Ballards since it opened, we have never had any cause to feel they are at risk and nothing but praise for the home and everyone involved with its running" and "Very caring and friendly."

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

● We saw that the complaints procedure was displayed for people but this was not in a pictorial or easy read format for some people who may need it available in this format.

● The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

● The registered manager told us they were happy to listen when people wanted to raise complaints and investigate these, however feedback received suggested when complaints were made these were not always welcomed. One relative told us, "The new manager is far from approachable, whenever a concern is raised I am dismissed and intimidated. I previously made concerns and was dismissed by both the care home

manager and regional manager."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People in the home had the opportunity to attend service user meetings and provide feedback through a survey. Not everyone in the service was able to understand this process or communicate their feedback beyond a yes or no response. Some people chose not to engage in this process.

● Feedback was also requested from health and social care professionals and relatives. The registered manager told us this fed back into the development plans for the service and helped identify areas they needed to focus on.

● The survey in 2019 was completed by 20 staff, four people, seven relatives and three health professionals. Feedback from staff included that they felt supported but that not all staff worked to the same level and support. They highlighted there were areas they did not feel confident in and would like more training. At this inspection this was also a theme that staff continued to raise.

● The registered manager shared with us their 2020 newsletter which captured people enjoying different activities such as food shopping, making pizzas and sitting in the garden.

Continuous learning and improving care

● The registered manager said they were supported by a regional director manager and the behaviour team but visits had naturally dropped off during the height of the pandemic. An internal COVID 19 group was also available for support.

● The registered manager was open about the pressures from trying to support people within the currently funded hours and told us, "This takes my time away from what I am meant to do such as supervisions, everyone should have had two but some only had one. Had so much time eaten up with what is going on with [person] and had to scan all paperwork to safeguarding. This meant I lost focus on other areas."

● Following this inspection, we had two virtual meetings with the chief operating director, regional director and the registered manager. From this the chief operating director was open to listening to the inspection findings and provided reassurance around wanting to address our concerns and take any necessary improvement action. The provider has decided to not fill any of the current vacancies to allow the home and the staff some breathing room to focus on the improvement and support needed within this service. A working action plan has been shared with us so we can see the immediate and longer term steps they are working towards.

Working in partnership with others

● The service had worked alongside a variety of different professionals and where they identified further support was needed they would contact the relevant professionals for people.

● Feedback from professionals who worked with the service was mixed. Some professionals expressed concerns that implementation of advice was inconsistent. One professional told us, 'I have found my interactions with management to be challenging at times and I have not always felt listened to. There is often detailed information given by management, but sometimes this is not relevant to the discussion. I am not always sure that the information I am delivering has been taken on board.'

● We saw that other professionals had given feedback directly to the service, some of this was positive and commented on staff working hard. Other comments raised the need for further training, namely around Makaton and the approach to moving and handing. The provider informed us that they are following up on these areas.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure staff were suitably skilled and supported to safely meet people's needs increased the risk of harm for people. There was a failure to review methods, amend measures and mitigate risks to people. The systems in place would not have prevented an infection from spreading and increased the risk of exposure for people. Regulation 12 (2) (b)(c)(f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to effectively evaluate and improve the quality of their practice for people and staff. There was a lack of good governance and oversight within this service. Regulation 17 (1) (2) (a)(b)(f).