Jeesal Residential Care Services Limited

Heathers

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Heathers is a residential care home providing personal care to eight people with learning disabilities, autism and mental health conditions at the time of the inspection. The service can support up to nine people. The care home accommodates people in individual self-contained apartments with ensuite bathrooms, kitchen and living area. Two apartments are in the main 'farmhouse' and the remaining accommodation is around an adjacent courtyard. There is communal outdoor space and a communal activity room.

The service has not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. Registering the Right support ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. At the Heathers there was a closed culture that did not support people to have maximum control, choice and independence and people using the service did not receive planned and co-ordinated person-centred support that was appropriate and inclusive for them.

People's experience of using this service and what we found
People were not kept safe at the service. There had been a number of serious incidents that put people in the service at risk. Some of these incidents included abuse by members of staff in the service. The provider did not always report incidents. Neither did they always act in a timely manner to take action to safeguard people following incidents to ensure they did not happen again.

There was a closed culture at the organisation which did not encourage staff to raise concerns when they witnessed poor practice or abuse. There was no system to monitor the quality of care in the service or the actions of the manager. The provider did not have a regular presence in the service to provide support to the registered manager and the senior staff. The registered manager and deputy manager both worked regular shifts supporting people in the service which meant there was no oversight of the service and they did not have time to monitor the quality of care and ensure records were up to date. This meant audits were not always completed and action wasn't taken following incidents to prevent things happening again.

Risk assessments and behavioural support plans did not always contain sufficient guidance for staff on how to keep people safe. There had not always been enough staff at the service which resulted in people sometimes sharing their one to one support. The provider had increased the number of staff available, but there was a high use of agency staff who weren't always familiar with people's needs. There were systems in place to ensure people received medicines as required. However, where people were prescribed medicines 'as and when required' this was not monitored or reviewed when people had these medicines on a regular basis. Other professionals told us they were concerned about a culture of 'containment and medication' rather than positive support for people. Fire procedures were inadequate. The provider reviewed these at our request following our first day of inspection.

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 and culture in the service did not support this practice. People were not deprived of their liberty in accordance with the law. Records and systems in place to support people with eating and drinking were inadequate and records contained contradictory guidance for staff. Some people did not always have care plans to provide guidance for staff on eating and drinking. Records of what people had to eat and drink for people at risk of malnutrition were not consistently maintained.

Staff training was not always effective and was not always put into practice. There was no system to monitor staff practice so the registered manager and provider could reassure themselves of staff competence. People were supported on a one to one basis in their own self-contained flats which did not provide opportunities for 'open' observation.

Staff were not always caring and respectful of people's privacy and dignity. There were a number of incidents where people's privacy and dignity had been compromised. People were not supported with their cultural needs. Care was not person-centred and care plans were not always reviewed when people's needs changed. Plans to support people with their behaviour contained generic advice directly copied from a template and had not been sufficiently personalised to reflect people's needs, and in some cases was contradictory to their needs. There were no activities on site and people were not supported to socialise with each other. High use of agency staff meant some people did not have the opportunity to go out into the community.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; there was a closed culture which did not always keep people safe, there was a lack of choice and control, limited independence, limited inclusion in the community and a lack of meaningful activity.

Prior to our inspection the provider had asked an external consultant to carry out an assessment of the service and they had put together an action plan based on their findings. This addressed some of the shortfalls but not all of the concerns we found at 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. The last rating for this service was Good (published 30 May 2019)

Why we inspected
The inspection was prompted by a notification of a safety incident at the service. The incident was subject to a police and safeguarding investigation. The information CQC received indicated concerns about the culture at the service. In addition, because the incident resulted in a number of staff being suspended, we were concerned about whether the service had sufficient staff to support people safely. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. After our first day of inspection we were concerned that standards fell below those expected in other the other key questions, so we widened the inspection to a comprehensive inspection.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heathers on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safeguarding service users from abuse, safe care and treatment, staffing, need for consent, meeting nutritional and hydration needs, dignity and respect, person-centred care, good governance, duty of candour and notification of other incidents.

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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Heathers

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 was carried out by two inspectors.

Service and service type
Heathers 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.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service and four relatives about their experience of the care provided. We carried out observations of staff supporting people. We spoke with twelve members of staff including, the registered manager, deputy manager, the operations manager for the provider, senior care workers, care workers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with one professional who

was visiting the service.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and disciplinary actions. 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 asked the provider to take some immediate action to ensure that people using the service were safe. We gained feedback from four professionals who were working with people in 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 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; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

• The service did not safeguard people from the risk of abuse.
• We found evidence of more than one incident where people had been subjected to abuse by staff.
• The provider did not always act immediately to safeguard people when incidents of abuse occurred.
• The provider did not always report incidents to the local safeguarding authorities in line with the law.
• The provider failed to report staff in a timely manner to the DBS authorities when action was taken against them, to prevent them working in similar services in the future.

Failure to act immediately to safeguard people from incidents of abuse is a breach of Regulation 13 (safeguarding service users from abuse and improper treatment) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff had been trained and understood how to identify safeguarding concerns. However, there was a culture of staff not raising concerns where they witnessed abuse. We found incidents of abuse that other staff were aware of but did not report. Some staff told us if they did raise concerns no action was taken.
• The safeguarding notification that was the trigger for this inspection concerned two separate incidents that happened 10 months apart involving four members of staff. None of the staff involved or those who had witnessed the incidents raised concerns or reported what had happened.
• There was a second serious safeguarding incident involving three members of staff which was not reported by any of the staff involved.
• Incident and accident records did not contain records of actions taken to prevent incidents from happening again.
• When incidents happened the provider and registered manager did not review them in a timely way to ensure action was taken to prevent the incident from happening again. In the week prior to our visit there was a serious safety incident as a result of the behaviour of one of the residents putting all residents at risk. Following the incident there was no update of the individuals risk assessments or the risk assessments and procedures for the environment of the service to ensure the incident did not happen again and people were safe. There was a repeated safety incident five days after the first incident and there was still no review of risk assessments or safety procedures.
• Staff told us that several people's distressed behaviours were escalating as a result of pressures on staffing and use of agency. One member of staff told us, there was no monitoring of people's safety because of the shortness of staff and people sharing one member of staff when they should be supported on a one to one.
•Risk assessments and behavioural support plans did not always contain guidance for staff on how to

support people with distressed behaviours to keep them safe. Risk assessments also failed to identify risks to other people.
• Fire procedures were inadequate for the service and there was no system in place for staff and people to sign in and out of the premises when they went into the community. Evacuation procedures did not consider the fact that managers were working in the service and therefore may be supporting people and not able to carry out fire marshal duties in the event of an evacuation.

Risks, including risks associated with distressed behaviours were not managed and action was not taken following safety incidents to ensure that incidents did not reoccur in the future. This was a breach of Regulation 12 (safe care and treatment) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We referred our concerns about fire procedures to the fire service. Following the first day of inspection we requested the fire procedures were updated and reviewed. The fire officer reported to us the revised procedures were adequate.
• Following the inspection we asked the provider to ensure that records in relation to some of the safety incidents were updated. They sent us copies of those records they updated and said they would need longer to update one of the records as it required more detail.
• Electrical tests and servicing of equipment had been carried out to ensure the safety of the premises.

Using medicines safely
• PRN medicines were not regularly reviewed. One person had medicines to help them cope with anxieties which was to be administered on a PRN basis, however this medicine was administered either every day or every other day. There had been no arrangement made to review the medicine in six months and the service waited for a scheduled appointment with the healthcare professional involved. The protocol states that staff should follow the Positive Behavioural Support Plan prior to administration, however there was no evidence of this.
• One professional told us they felt the service relied on 'containment and medicines' to support people rather than try to provide positive support to help people with their distressed behaviour.

• One person who had their medicines administered outside of the usual medicine rounds was given a double dose of their medicine. The MAR chart stated the incorrect time for the medicines to be administered which contributed to the error.
• People's medicine care plans were not accurate. Two people had medicine care plans that stated they should have medicine before food. We observed one of those people being given medicine after their breakfast. The registered manager told us that the prescription did not specify medicines should be after breakfast care plan was not accurate.
• The provider had a system where audits of medicine administration should be completed every month. However, these had not been completed in the two months prior to the inspection.

Medicines was not always managed safely and reviewed in a timely manner. This was a breach of Regulation 12 (2) b (safe care and treatment) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• The registered manager told us they addressed the concerns with records of medicines after our inspection to ensure records were accurate.

Staffing and recruitment;
• The service did not always have enough staff to support people. We looked at the rotas prior to the inspection and they showed the service regularly operating with one or two members of staff less than they

required. The suspension of staff members following concerns about their practice has an additional impact on staffing levels.
• Staff told us there were not enough staff to support people's needs and there was high use of agency to cover absences. One member of staff said, "It runs you down being short staffed." They went on to say they felt they were "flitting between people." There was additional pressure on female staff as some people needed to be supported by female staff and there was a shortage of female support staff in the service.
• Agency staff did not always understand how to support people. They were also not able to carry out the full range of duties such as taking people out in vehicles which meant some people were not supported with engagement in the community and meaningful activities.
• Some people needed to be able to build rapport with the people that supported them. The core staff were focussed on supporting these people which left other people with agency staff who were not familiar with their needs.
• There were some people who had to share one to one support. For one person this meant that they couldn't go out when they wanted to. Another person was at risk of choking and so had to wait to be supported at meal times to ensure a member of staff was able to support them.

Not ensuring there are sufficient staff with the skills and knowledge to support people is a breach of Regulation 18 (staffing) of the Health and Social Care Act

• The provider was currently recruiting to the vacant positions but told us this was challenging. They had also redirected staff from their other services and secured more agency staff so that they were meeting the required numbers of staff on shift.

Preventing and controlling infection
• The service was clean. People were supported by staff to clean their apartments where possible.
• Staff were aware of how to prevent and control the risk of infections and used PPE when supporting people with personal care. We observed people regularly washing their hands when supporting people.
• The provider had systems in place to ensure the safety of the water supply and mitigate the risk of infections such as legionella.

Inadequate

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 this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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.

• People's liberty was restricted but without the necessary legal safeguards in place. Two people had DoLS authorisations which had expired. For one of these a recent new application had been made, for the other no further application had been made
• The service did not have a way of tracking DoLS applications, and the registered manager and provider were not aware of who had applications or authorisations in place.
• Staff understanding of the MCA was poor. Staff did not know who had a DoLS in place. The registered manager did not understand that a DoLS application could only be made where a person did not have capacity.
• Where mental capacity assessments had been carried out, and people were deemed not to have capacity the best interests' decisions did not show any consideration for the least restrictive option. For example, one person's MCA just said that their doors should be locked.

Failing to ensure adequate safeguards are in place where people's liberty is restricted is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act

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

• One person was at risk of malnutrition. There had been a recent referral made to the dietician. However, when we looked at records, we found that staff were not consistently recording what the person was eating and drinking at every meal. Several meals had not been recorded at all.
• There was contradictory information in the records about the person's diet. In a safety care plan for eating and drinking it said the person should not be offered foods with high calorific value, but elsewhere in the care plan documents there was guidance on ensuring high calorific intake.
• The system for supporting people with mealtimes had been changed so that instead of each person cooking in their own apartment, food preparation was done in three apartments sharing the food with people living in other apartments. This arrangement had been put in place without considering the appropriateness for each individual.
• One person did not have any eating and drinking care plan in place so there was no guidance for staff on their likes and dislikes or the preparation of food which could sometimes cause them anxieties. One member of staff told us this person had also had intolerances to some food in the past, but there was no record of this.
• Another person's care plan was not consistent around how they needed to be supported with their food. In one part of an eating and drinking care plan it said they were at risk of choking and should always be supervised when eating, but in a support plan 'things I can do for myself and support I need' it stated there was no risk of choking.

Failure to provide people with effective support around eating and drinking is a breach of Regulation 14 (meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The service did not holistically assess people's needs and deliver care and support in line with registering the right support.
• Information in people's care plans was often contradictory and did not provide consistent guidance for staff.
• Care plans did not contain information about people's hobbies and interests, where this was available it was often generic and not personalised to the individual.

Staff support: induction, training, skills and experience
• Staff had attended a mixture of e-learning as well as face to face training. However, this training was not always effective. For example, staff had been trained in safeguarding, but did not always report safeguarding concerns and staff did not have a good understanding of the MCA.
• Staff told us they had attended training on managing people's behaviours and while aspects of the training were good, they said it was difficult to understand how to apply the training to the people they were supporting.
• There was an induction programme for new staff which required them to complete the care certificate and this involved staff being observed carrying out their role. However, there was no ongoing monitoring of staff practice and observations of care. The structure of the service made this difficult because people lived in their own apartments.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People were supported to access healthcare. However, the service was not always proactive in ensuring this happened. Healthcare concerns were often picked up at routine scheduled meetings rather than as a result of a direct referral made by the service.
• Healthcare professionals told us they had concerns about the service. More than one professional told us

the registered manager did respond to their input but raised concerns that the provider did not provide the necessary support for them to fully implement recommendations. Another professional told us they thought the service was now starting to make the changes necessary, but it was very slow and questioned why it had taken so long.

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

• The service was in an isolated location which made engagement with the local community difficult. The premises had not been adapted to create pleasant spaces for residents to socialise together. There was an activities room. This had a large table and chairs and was set up for table activities. There were no comfortable armchairs and sofas which might encourage people to socialise in the evenings. The room was still decorated with Christmas decorations three months after Christmas, which indicated it was rarely used.

• People lived in self-contained apartments which were decorated to their own style and choice. We did not see visual signs in people's homes to help communication or to help promote people's independence. The service had been developing 'now' and 'next' boards for people, so they knew what was happening on each day however these had been planned for several months and were still not used. There had not been any individual assessment of people to assess whether these were appropriate for each person.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At 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 treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- The safety incidents that had happened at the service compromised people's privacy and dignity.
- Staff observed people in a distressed state and did not always act to protect their privacy and dignity.
- Agency staff were not always sufficiently skilled or knowledgeable to support people which lead to situations which did not always uphold people's dignity.
- People's cultural needs were not always considered in a proactive way, which created barriers to communication causing distressed behaviours.
- People were not always supported to access the community and develop their independence skills. People were not supported consistently with hobbies and interests.
- There was evidence of staff making fun of people and their mental health difficulties.

Failing to uphold people's privacy and dignity was a breach of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- On the second day of inspection the service had begun to consider cultural needs.
- Cooking arrangements changed after the first day of inspection to enable people to be supported to prepare food in their own apartment where possible in order to promote their independence skills.
- Relatives told us the registered manager discussed their family members care needs with them.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

• Care was not person-centred. Support was not personalised and in line with registering the right support. There was no clear information in people's care plans about people's history, hobbies and interests. Even where this information was available, staff had not always acted on this to find activities they would be interested in. One relative told us, "Of course when we first came, they used to do more with [name]. Take [name] further afield. Nowadays [name] doesn't seem to go so far."

• The registered manager told us it was difficult to keep up with reviewing care plans following incidents or if people's needs change because they did not have the time.

• Activities did not happen at times to suit people's individual needs and tended to be organised around the times it was best for staffing numbers.

• There was no personal information followed up to encourage people to participate in meaningful activities and clubs, despite the fact people's positive behavioural support plans suggested this as an action. One person told us they used to like to go out in Norwich in the evenings, but they had not been able to do this since moving to the service.

• There were few social activities on site. There was a communal games/activities room, but there was no evidence of this being used on a regular basis. The registered manager told us they had tried to introduce a communal meal once a month which some people enjoyed, but this had not been kept up and no other communal activities explored.

• Only two people attended day services. There was no evidence of hobbies or interests being followed up to enable other people to attend day services or engage on a regular basis in activities in the community.

• Trips to the community often were just going for a drive or going to a supermarket and getting a 'meal deal' lunch, rather than more meaningful activity.

• Positive behavioural support plans contained information that was copied from the template form and was not personalised to people's individual needs. For example, several plans we looked at contained the following phrase, "Expose [name] to other people and support [name] with interactions" and "Research activities in the locality for [name] in line with [name] current interests." For one person this was inappropriate as social interactions caused them anxieties.

• Agency staff were not always familiar with how people needed to be supported and core staff were used to support those people who required people they were familiar with, so agency supported the rest. The consequence was that those people supported by agency were unable to go out.

Failing to provide personalised care and support people with interests and hobbies and meaningful

engagement with the community is a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
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.

• The service supported people who were unable to communicate verbally. We saw little evidence of appropriate signage in people's apartments to help them communicate. For example, if people used sign language there were no images of signs and symbols that could be used to aid communication. This would be particularly important with the use of agency staff who were not always familiar with people's communication needs. Staff told us that agency staff did not always understand sign language and therefore could not use it to communicate with people.
• Some information was available in easy read format to help people understand. For example, medicine care plans were in easy read format and the provider had started creating an easy read overview for each person.
• Staff had training in the signs that people used, and we saw some evidence of staff using those signs to help people communicate.

Improving care quality in response to complaints or concerns
• There was an accessible complaints procedure in people's care files and there were systems in place to support people if they needed to make complaints.
• Relatives we spoke to told us they knew who to speak to if they had any concerns and told us the registered manager listened to what they had to say.
• It was not clear how people using the service would be supported if they wanted to make a complaint given the poor culture within the organisation.

End of life care and support
• The service was not currently supporting people at the end of their life.
• The provider told us they were introducing and end of life learning module as part of their future strategy.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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.

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

• There was no clear leadership in place at the service. The registered manager was covering shifts to support people due to the low staffing numbers this meant they did not have time to maintain full oversight of the service. In the first week of March, the registered manager had worked 27 hours providing direct care in addition to managerial hours.
• There was a closed culture within the service in which concerns were not raised by staff and escalated to managers. Where there were serious safeguarding incidents, staff who had observed the behaviour had not spoken up and reported concerns. One member of staff told us when they had reported a concern about a colleague's behaviour to a senior member of staff they had been told, "Oh yes [staff name] always does that." This indicated that the senior member of staff was aware of the behaviour but had not done anything to challenge it.
• Staff told us the culture was negative. There had recently been some coaching training with senior staff, but staff who attended told us this had not been followed up with front line staff and carers.
• Staff told us roles and responsibilities had become confused, especially since staff had been suspended as there was only one senior carer on the day shifts and they would be leaving. Other staff had been made key holders to take on some senior duties and the manager and deputy were both working regularly in the service.
• The provider did not monitor staffing levels within the service. Staffing levels were low and as a result, core staff were becoming burnt out and morale was low.
• There was no system in place to monitor staff's competence and quality of care and support to people. Most care was one to one in people's apartments and unobserved by managers. There were no systems in place for managers to reassure themselves that standards of care were maintained. Staff told us the components of the care certificate requiring work-based observation were sometimes signed off by a senior member of staff without being observed. The registered manager told us it was difficult to observe staff competency as you had to knock on the door to go into a flat to observe people which meant staff would behave differently once the manager arrived.
• Systems in place to audit and monitor the quality of care were not fully implemented. Senior carers had completed some of the audits as required but these had stopped in the two months prior to the inspection

when staffing numbers dropped.
• Audits that had been completed had not identified where concerns should be escalated. For example, medicine audits did not highlight if people were taking PRN medication on a regular basis and when medicines needed to be reviewed.
• The registered manager was in the process of putting care plans on to an electronic system and was updating them at the same time. The provider did not carry out an independent audit of people's care plans to ensure they reflected people's needs.
• Staff told us they could speak to the manager but when they raised concerns no action was taken.
• Action was not taken following incidents to ensure that incidents did not happen again. There was no culture of continual learning and improvement. Following a safety incident prior to the inspection no action was taken to improve procedures or update care plans. A similar incident then reoccurred in the week.
• The provider did not have systems in place to monitor the quality of care delivered by the service and the duties carried out by the manager. For example, they were not aware that audits had not been completed.
• The registered manager reported that they did not get support from the provider. On the day of inspection and the day after the inspection despite the fact we had raised concerns the registered manager continued to work alone although the provider did provide some support remotely. Professionals we spoke with also said they felt the manager was 'left to get on with it.'
• Staff were generally positive about the manager and the deputy and said they often worked shifts on the floor, this took away from the time they had for administration and several staff also told us they felt the registered manager and deputy didn't get the support from the provider.

Failure to create an open culture where concerns can be reported and are acted upon and failure to effectively monitor the quality of care delivered by staff is a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had arranged for an external consultant to carry out an assessment of the service and put together an action plan for improvement. This action plan had identified some, but not all of the concerns we raised. It did not have timescales by which actions were to be completed.
• Following concerns being raised, the provider had started to address the staffing issues by recruitment as well as contacting other services within their portfolio to support the Heathers.
• Following the inspection, we asked the provider to send us an updated action plan We received the action plan which included timescales for actions to be completed. However, we remained concerned about the timeliness of some of the actions in the plan.

• The nominated individual had failed to respond appropriately to safeguarding concerns that put people living in the service at risk on more than one occasion.
• The service had not spoken to a relative about a safety incident that occurred until we requested that they do so. It is a requirement under the duty of candour that providers are open and honest where things go wrong, provide support to the person and or their representative and issue an apology.

Failure to be open an honest with regard to safety incidents is a breach of Regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider failed to notify the commission of safeguarding incidents as they are required to do by law.

Failure to report to the commission allegations of abuse is a breach of Regulation 18 (Notification of other incidents) Care Quality Commission (Registration) Regulations 2009.

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

characteristics
• The service did not have a system of resident meetings in place. The operations manager told us they were reviewing this and would be setting up a system of individual engagement with people using the service to enable them to give feedback and raise concerns.
• Relatives told us that when they spoke to the registered manager or staff, they updated them about their family member. One relative told us, "When I ring up and ask how [name] is and they tell me if [name] is OK." However, there wasn't evidence of the service taking proactive action to engage and gain feedback from relatives. One relative described how it had taken a lot of effort on their part to get the family members care plan reviewed and accurate and for them to get the support they needed.

Working in partnership with others
• The service worked with other professionals, including GP's, community nurses and advocates. However, all the professionals we spoke with raised concerns about the service.
• The service had links with day services that some people attended on a weekly basis.