Outlook Care

Foxburrow Grange

Inspection report

Ypres Road
Colchester
Essex
CO2 7NL

Tel: 01206586900
Website: www.outlookcare.org.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Foxborrow Grange is a residential care home providing personal and nursing care to up to 69 people across 4 separate wings, 2 wings specialise in providing care to people living with dementia. At the time of our inspection there were 63 people using the service.

People's experience of using this service and what we found
People's relatives told us they felt their loved ones received good care and were safe. However, we found people's care and support was not always planned in an individualised or personalised way. The care provided was not always responsive to the requirements of people with more complex needs.

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. Management and staff did not recognise unnecessary control as restraint, including during personal care or inappropriate use of medicines which placed people at risk of harm.

Systems to identify and address potential risks to the health, safety and welfare of people were not effective. Risks to people becoming asphyxiated due to having bed rails or obtaining skin tears from metal brackets fixed to wall to protect damage from the bedhead had not been adequately assessed. People's records contained insufficient information about risks associated with medical conditions. Individual fire risk assessments and evacuation plans had not considered all factors to affect a safe evacuation for the person in the event of a fire.

Systems in place to ensure the safe administration, ordering, storing and recording of medicines were poor, which placed people at risk of harm.

Systems to protect people from behaviour that presented a risk to themselves, or others was ineffective. Staff had not been provided with the training they needed to meet the specific needs of people using the service, including how to recognise and de-escalate early signs of distress or effectively manage people's heightened anxiety.

Recruitment practices needed to improve to ensure all relevant documentation was obtained to ensure fit and proper staff were employed to work with people using the service. Staff were not routinely provided with appropriate supervision and appraisal to enable them to carry out the duties they were employed to perform and ensure they were competent to meet people's specific needs.

The service used the Montessori Approach adapted for older people who are living with dementia. This approach promoted individualised care to enable people to get the most out of each day. We did not always see evidence this approach was being applied or how it improved outcomes for people. We saw and records showed there continued to be high levels of people's behaviour escalating due to increased anxiety and

distress being managed via sedative medicines. There was an abundance of group activities for people who were able to participate, however further consideration was needed to improve the experiences of people with more complex needs on an individual basis to promote their well-being and meet their emotional needs.

The registered manager told us a small minority of people using the service had a learning disability. 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 local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of the effective key question, the service was not able to demonstrate how they were meeting some of the underpinning principles of the Right support, right care, right culture guidance. This was in relation to overuse of medicines to manage people's behaviour and the size of the care setting, which as a larger service is not in line with usual best practice for accommodating people with a learning disability. The registered manager was not aware of this guidance but informed us the primary care needs of those people with a learning disability was nursing. They told us they would ensure they were up to date with the guidance. From 1 July 2022, all registered health and social care providers must ensure that their staff receive training in learning disability and autism. Staff had been assigned to complete this training.

People were supported to eat and drink enough to maintain a balanced diet. Staff supported people to access healthcare services and support when needed. The provider had embraced technology, including trials of a new falls system being installed to reduce falls. Infection prevention and control was being well managed keeping the premises clean and preventing outbreaks of infections.

We found the leadership, governance and culture did not support the delivery of high-quality, person-centred care. Systems to assess and monitor the quality and safety of the service were ineffective. Auditing processes did not provide an accurate overview of the service; ensure proper monitoring and review, identify shortfalls or inform an ongoing plan for improvement. Information from incidents, investigations and complaints were not learned from and used to drive improvement. Whilst it is recognised the registered manager took immediate action to make improvements, following the inspection, the governance arrangements had failed to identify the compromised quality and safety of the service.

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 11 February 2021)

Why we inspected
This inspection was prompted by a review of the information we held about this service. We received concerns in relation to the management of service and a lack of falls management resulting in injuries. As a result, we undertook a focused inspection to review the key questions of safe and well led. During the inspection we found there were concerns in other areas of the service, so we widened the scope of the inspection to become a comprehensive inspection which included 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.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led relevant key question sections of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, failure to protect people from unnecessary control and restraint, including the excessive or inappropriate use of medicines and governance arrangements at this inspection.

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 well-led findings below.	**Inadequate**

Foxburrow Grange

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors, a medicines inspector, 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
Foxborrow Grange is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Foxborrow Grange is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced. Inspection activity started on 13 March 2023 and ended on 15 March 2023. We visited the location's service on 13 and 14 March 2023. The Expert by Experience made telephone calls to people's relatives on 15 March 2023.

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 (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We 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. We spoke with 5 people using the service, 16 relatives, and 2 nurses, 5 members of staff including 1 senior, and the well-being co-ordinator. We spoke with the management team comprising of the registered manager, deputy manager, ward manager and wing supervisor. We also spoke with the property and maintenance manager, a cleaner/laundry assistant, and the head chef.

We reviewed a range of records, including 8 people's care plans and associated risk assessments, 9 people's care plans and 19 records relating to medicines and a variety of records relating to the management of 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 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.

Systems and processes to safeguard people from the risk of abuse

- Systems to protect people from behaviour that presented a risk to themselves, or others was ineffective.
- There was no information to support staff on how to recognise and de-escalate early signs of distress or effectively manage people's heightened anxiety. There were a high number of incidents of unsettled behaviour which at times presented as aggressive.
- Personalised calming techniques or other agreed good practice approaches were not in place to enable staff to support people in a consistent and positive way.
- Information recorded in people's daily records focused on the impact and risk to staff showing a lack of understanding of the person, and awareness of behaviours being a form of communication or expression of distress and anxiety.
- Staff were administering 'as and when required' medicine on a regular basis to control some people's distressed behaviours. One person was administered 18 doses of a sedating medicine between 14 February 2023 and 6 March 2023. Staff were not always recording why they had given a PRN medicine or what interventions had been tried or the outcome in care notes. There had been no internal review to identify triggers or themes for distressed behaviours that could be addressed differently.
- Management and staff did not recognise subduing a person's movements during personal care was restraint. Management did not keep records for when it was thought necessary for personal care to be carried out by more than 1 staff in this way to monitor for safety. We raised a safeguard alert about this practice.

Failure to have systems in place to recognise and protect people from unnecessary control and restraint, including the excessive or inappropriate use of medicines placed people at risk of harm. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Systems to identify and address potential risks to the health, safety and welfare of people using the service, were not always effective.
- Moving and handling plans did not include sufficient instruction for staff with regards to the lifting equipment needed to safely transfer a person into bed, or how staff would assist them from the floor if they fell.
- Where bed rails had been fitted, the risk assessments had not assessed the compatibility of bed rails, bumpers, and the risk of the person from asphyxiation.
- Assessments did not always identify and address risks in relation to people's medical conditions, such as inflammation of the oesophagus (oesophagitis), pre-diabetes, osteoporosis, and seizures.

● Risk to people's safety from the environment was not always recognised or addressed. Wall bumper bars had been fixed to bedroom walls to protect the wall from the bed headboard. Where beds had been placed lengthways against the wall the bumper bar no longer had a purpose. We saw a number of these had lost the ends of the protective cover; causing the protective cover to slide and expose the end of the sharp metal bracket beneath. This posed a risk of serious harm to the occupant of the bed.
● There were no records in place to demonstrate clinical equipment such as suction machines were regularly and routinely checked to ensure they were in safe working order. Blood glucose checking machines were not routinely calibrated to ensure the readings were accurate.
● People's individual fire risk assessments and evacuation plans had not considered all factors that may affect a safe evacuation such as the use of flammable creams, night sedation or heightened anxieties with associated behaviours.
● Systems for reviewing and investigating incidents, accidents and safeguarding needed to improve. Although incidents, accidents and falls were logged, there was no analysis to look for trends, triggers, and root causes to identify any preventative measures that can be taken to improve outcomes for people.
● Completed records did not demonstrate learning from lessons was shared well to make sure action was taken to improve safety across the service.

Using medicines safely
● People were not always receiving their prescribed medicines as intended, putting them at risk of harm.
● Staff had not given some people their prescribed medicines because they were asleep. One person had missed 74 doses of their prescribed medicine over a 4-week period.
● Systems to check stock levels of medicines were not robust, resulting in medicines not always being available when people needed them, or an overstock of some medicines.
● Protocols in place for people prescribed 'as and when required' [PRN] medicines did not contain enough information for staff to ensure they were able to support people with PRN medicines safely, including how and when they need to be administered.
● Records did not show why and when PRN medicines had been administered.
● Twenty-two people were being administered their medicines covertly. Where people had been assessed as needing covert medicines (medicines hidden in food and drink) there was no agreed management plan for administering a person's medicine in this way including details of how it was to be reviewed.
● There were no individual risk assessments in place for people prescribed medicines with side effects which could cause bleeding or bruising more easily than normal.

Failing to robustly assess the risks relating to the health, safety and welfare of people and failing to ensure the safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Records showed senior staff had received training to administer medicines and their competency was assessed on 3 occasions before they were deemed competent to administer medicines.

Staffing and recruitment
● Staff confirmed and observations showed there were enough care staff deployed to meet people's care and support needs. However, there were insufficient numbers of nurses deployed to meet the increased nursing needs of people.
● Staff told us an additional nursing shift to assist with the increase was inconsistent. The tool used to calculate correct number of staff with the right mix of skills to meet people's needs did not identify nursing needs. The registered manager confirmed after the inspection the additional shift was going to be a permanent fixture each day.

● Improvement to recruitment practices was needed to ensure people were protected from the employment of unsuitable staff. Recruitment documentation did not contain the information required in law regarding the prospective employee's full employment history; where there were gaps, they had not been explored further, recorded and risk assessed.

Preventing and controlling infection

● We were assured the provider was promoting safety through the layout and hygiene practices of the premises. The service employed enough cleaning staff, who followed robust cleaning schedules, including regular deep cleaning. The premises was clean and tidy.

● The provider had taken action to minimise the spread of infection, installing a digital thermometer, touchless hand sanitisers and swipe cards replacing keypads reducing the number of frequent touch points in the service.

● Staff were observed using personal protective equipment (PPE) effectively and safely. However, some staff were choosing to wear masks, where this is no longer a requirement but were observed wearing these under their nose rendering them ineffective.

Visiting in care homes

● People's relatives and loved ones were able to visit whenever they chose.

●The registered manager told us it is not a requirement for people to book appointments but if they wanted one of the specific communal areas then it was advisable for relatives do book to ensure availability.

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 good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 service had not always assessed people's mental capacity to make decisions, in a way that met legal requirements, and demonstrate it was in the persons' best interests.
- Clear procedures were not in place for giving 22 people their medicines covertly, in line with the Mental Capacity Act 2005 and best interest principles.
- Documentation did not demonstrate the decision to administer medicines covertly was made within a robust best interest decision making process. The decisions cited the same reason for; the person may refuse their medicines.
- Where people had fluctuating capacity to make decisions, there had been no review or guidance for staff to ensure people, when they had capacity, were able to take their medicines normally.
- Some people's care plans referred to them lacking capacity, but staff had not always carried out decision specific assessments to determine this judgement.

Staff support: induction, training, skills and experience
- Staff training was not proactively planned for or monitored in line with people's specific needs, staff learning gaps or best practice. For example, staff had not received required training in learning disability or training relevant to meeting people's specific healthcare needs such as acquired brain injury and catheter care.
- The registered manager told us, due to COVID-19 they had fallen behind on essential practical training such as fire safety, but this had since been booked.

● Staff had not received relevant training to support people experiencing episodes of heightened anxiety and distress; to de-escalate situations and protect the person, themselves, and others. Records showed staff and others had sustained assault and injury during these incidents.
● The provider's statement of purpose stated staff were provided with training for reducing resistance to essential care, however staff told us, and records confirmed staff had not been provided with this training.
● Nursing staff were being supported to complete self-directed learning to maintain their professional development and retain their registration with the national midwifery council (NMC)

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs
● Care and support was not always being provided in alignment with current standards and national best practice guidance to support good outcomes for people.
● A small minority of people using the service had a learning disability. The registered manager advised their primary need was nursing care which was being met by the service. However, the Commission's guidance Right Support, Right Care, Right Culture for supporting people with a learning disability was not familiar to management and had not been considered.
● The building is purpose built suited to its stated purpose and people's diverse and support needs, but as a large service does not follow usual best practice for the size of a care setting accommodating people with a learning disability.
● The premises had been decorated to a high standard, to include a range of communal areas, such as a library and themed quiet areas with good views out of the window.
● Decoration had been designed in line with the Montessori approach aimed to empower people living with dementia. For example, doors to people's rooms in the dementia units, had been shaped and painted to look like front doors, complete with door knockers, and letters boxes.
● Illuminated, glass covered memory boxes filled with memorable items and photos had been fitted beside their front door to help people recognise and identify their room.
● Specialist equipment, such as overhead hoists, pressure relieving mattresses, profiling beds, were available to ensure people were transferred safely and to prevent skin damage.
● The provider had embraced technology, including a trial of a new falls system being installed to reduce falls.
● People's rooms were spacious, nicely decorated, and personalised. All had ensuite toilets and walk-in shower facilities, and communal toilets had red seat covers to help with identification.

Supporting people to eat and drink enough to maintain a balanced diet
● Observation of mealtimes across all 4 wings found people had access to sufficient food and drink throughout the day to maintain a healthy diet.
● Staff supported people, according to their needs, providing encouragement to eat and drink. Where people needed assistance to eat and drink, this was done at the individual's pace, so they were not rushed.
● People were provided with adapted cutlery enabling them to retain their independence, when eating and drinking.
● People were provided with a good choice of food, including a hot cooked breakfast, and up to 3 meal options daily to include meat, fish or vegetarian options. Other options were also available. Fortified drinks and shakes were offered during the day to maintain people's weight.
● Training information provided confirmed staff have been provided with awareness of swallowing difficulties and dysphagia training. Staff, including the chef were aware who had specialist diets, and those at risk of choking.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support

- The service worked collaboratively with other professional to understand and meet people's needs.
- Regular referrals to other health care professionals were being made when needed, including dementia services, mental health teams, dieticians, speech and language therapist (SaLT), diabetic service and tissue viability nurses (TVN).
- Where required people received regular follow up reviews from the relevant healthcare professionals.
- The management team told us there had been issues with information sharing and communication between them and the GP practice and associated pharmacy which required mediation to resolve the issues.

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
- The Management Team told us the Montessori approach had been implemented on the dementia unit, referred to as Badger and was in the process of being implemented on Squirrel.
- There were elements of this approach that worked well for those people living with dementia who were still able to participate in group activity. However, staff told us, this approach did not work for all people, especially people with communication and sensory needs.
- Whilst staff were seen to be caring and respectful, improvement was needed to ensure everybody was well supported. One relative commented, "I'm happy with the care, generally enough staff, but when people are not quite so calm, staff are seen running around."
- There were times where people were not always occupied and were walking around becoming agitated or emotionally distressed. One relative told us, "[Person] is very kind and forgiving; but there are people in their unit that's screaming all the time, so they have to try and shut themselves in their room because its distressing."
- Where people remained in their rooms, we saw they were not receiving the same level of social interaction, as those who were mobile.
- Relatives provided positive feedback about the caring attitude of the staff. Comments included, "Staff are really good, lovely and engaging and they are good at gaging what people want," and "[Person] has dementia so there are some difficulties, because they are also deaf, but the staff are absolutely marvellous with them; they are very patient and kind".

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence;
- Relatives told us they were involved in making decisions about their loved one's care. One relative commented "My [Person] can't make a decision for themselves, so I have to know what's going on and make the decision for them."
- Although relatives were involved in decision making, they told us plans of care recommended by other health professionals were not always being followed. One relative commented, "I don't know if it's because of a change of staff throughout the day or night, they have been given instructions on how to care for my (Person) but these are not followed through, and the carers don't seem to be aware of what to do."
- People have been involved in discussing the environment, food, activities, and events.
- The head chef told us they were preparing new menus and people had been asked about their preferences and choices. They told us pictures were used in the process to help people choose.
- People and their relatives told us, staff were kind, caring and respected people's privacy and dignity.

Comments included, "Absolutely, yes, [Person] gets good care; I definitely believe staff promote their privacy and dignity," and "[Person] is always dressed and presented well and I don't think there any issues around their dignity at all".

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; End of life care and support

- People's care and support was not always planned in a personalised way to ensure they received the right level of care, including those with more complex needs.
- Plans of care were inconsistent and did not always reflect person centred care. They were vague in relation to the varying stage of dementia people were at.
- Care plans did not always inform staff of people's strengths or the type and level of support they needed to keep their best independence and promote their wellbeing.
- Care planning arrangements and discussions relating to end of life mostly focused on after death care such as preference of burial/cremation and funeral. Preferences and choices about care delivery at the end of the person's life had not been communicated and clearly recorded. Some stated, 'further discussions required'.
- Meaningful conversations with people as part of their ongoing assessments and reviews had not always taken place and would help to prepare a plan for the delivery of their end-of-life care.
- Care plans did not always contain advanced directives, for the co-ordination of the persons care and the arrangements in place for rapid access to support a dignified and pain free death.
- The registered manager told us that there were documents relating to people's end of life however they were not accessible to the staff delivering the care.

Improving care quality in response to complaints or concerns

- People told us they were able to complain about the service if they needed to. One person told us, "I would know how to make a complaint, but I am not sure we know the correct complaints procedures, we have just spoken to staff if there are concerns, but no major issues. I do think they would listen".
- Whilst complaints were addressed by management the initial concern was not being investigated properly to identify root cause or used as an opportunity to learn and drive continuous improvement.
- For example, the response by the registered manager to a recent complaint raising concerns about a person's care, was a list of dates and interactions, with no overall conclusion, or outcome to the concerns raised.

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 providers statement of purpose reflects the service provides support to people with sensory impairments. Although information was available about safeguarding, whistle blowing and who to contact to raise concerns, this was in standard sized print.
● Information about the service needed to be made available in easy read formats and larger print for people with dementia, learning disability and sensory impairments to read.
● Signage across the service had been changed to a yellow background with black writing to make it easier for people living with dementia to read.
● To meet the communication needs of people with a disability or sensory loss the service had initiated tools, such as social story' picture books and flip books. These aids had been designed to help people process a particular situation, event or activity, and lower levels of distress.

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
● There was an abundance of group activities for people who were able to participate, delivered by the wellbeing co-ordinator in the activity hub each day Monday to Friday.
● Feedback regarding the wellbeing co-ordinator was positive, comments included, "Wellbeing co-ordinator is amazing" and "Wellbeing co-ordinator is very jolly and encourages people; they do their best."
● People enjoyed social events including links with the local community. One person told us how they were encouraged to maintain hobbies and interests, and another showed us, paper flowers they had made to make a bouquet.
● The wellbeing co-ordinator and staff spoke positively about the implementation of the Montessori approach, and described some positive examples, of how this worked in practice.
● One member of staff told us, "It's about getting people to do their own thing, by tuning into their abilities, and get them involved in routine activities, for example, [Person] loves painting, so when we had decorator's in, we gave them a paintbrush and water so they could join in the painting. It's their home, we help them to do what they want to do."
● Activity provision was not always at a level, which met the individual and specific needs of some people using the service. Whilst a wide range of group activities were thoroughly enjoyed by many people including arts and crafts, music and movement and the Foxburrow Foxy Foxes choir. Further consideration was needed to improve the level of interaction people experience on an individual basis to promote their well-being and meet their emotional needs.

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

Our previous inspection found the providers auditing process had not identified some medicines were out of date. At this inspection we found systems to assess the quality and safety of the service were still not being used effectively to identify what was working well, and where improvements were needed.

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

- The management team failed to recognise and identify significant failings impacting on the quality and safety of service provision.
- Whilst a large volume of audits were regularly carried out, they did not identify shortfalls in quality and safety. For example, the medicines audits carried out in February 2023, scored 98.25 % and failed to identify the concerns about medicines found during the inspection.
- Twelve falls between January and February 2023 had occurred during the afternoon, however there was no analysis to determine any potential trend or theme which could be addressed to prevent future falls.
- There was no robust analysis of information to identify strengths and weaknesses of the service delivered or see what could be done better and drive improvement.
- Whilst a lot of effort had gone into developing the Montessori approach, the registered manager was unable to demonstrate how they monitored the approach to ensure it was being applied as it should and to see how it improved outcomes for people.
- For example, on Badger wing, where the Montessori approach was established there continued to be a high level of incidents where people's behaviour escalated due to increased levels of anxiety and distress.
- Relatives told us they were not aware of the Montessori Approach or how it impacted on their loved ones. Comments included, "I do not know anything about Montessori so I can't say what benefits [Person] would get," and "I don't know about any new service or program they are doing; I don't know what it is and whether it would be any good for [Person]".

Failure to have robust systems and processes in place to assess, monitor, and improve the quality and safety of the service is 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; 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

- Since our last inspection, the service has had a lot of staff changes including a new management

structure. Concerns were shared with us about the new management team not being supportive, not having enough oversight, poor team working and low staff morale.
● Supervision records showed issues had been raised regarding staff relationships and team working. However, there was nothing to show how staff were being supported, what action had been taken to resolve these issues and ensure values and behaviours were promoted.
● Staff told us morale had been low but felt this had started to improve in recent months. This was confirmed by a member of management team. They commented, "Of late seems more settled, we've done a big recruitment drive, we are using less agency, and staff seem happier."
● People's, relatives spoke positively about the service and the registered manager. Comments included, "There is a positive vibe at the service; I think they are open and honest about what they do and yes, they are fair. I think they do promote positive values," and "The manager is really nice, they have always been available to me, I don't think they are always aware of the issues at the home that can be problematic, but they are very accommodating and will sort things".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Questionnaires had been sent to people's relatives and staff to obtain their views of the service. The outcome of these surveys had been documented in a you said, we did report.
● Neither the relatives or staff surveys were dated and did not reflect what period they referred to. Both sets of surveys, showed there had been a low response rate, giving only a small percentage of feedback. No further consideration had been given to how they could improve this.
● People's relatives told us communication between them, the management team and staff was good. Comments included, "Yes totally, I am informed, I will get phone calls and we call all the time; there is constant communication with me and the home," and "Yes the nurses are very good, today they rang about the eye test, so yes they do keep me informed."

Working in partnership with others
● The activity co-ordinator had forged strong links with the community. They had worked with charitable organisations to improve people's quality of life, which included the following:
● Hosting a local Bake-Off competition between 8 care homes attended by the town's Mayor.
● Setting up a choir for people using the service called Fox burrow's Foxy Foxes which currently had 15 people and some relatives in the choir.
● A pen pals scheme with children from a local primary school
● Work with a local charity who provided a range of services to help enable social action to improve people's wellbeing
● Links with local nursery childminders who bring in children to do arts and crafts with people and singing.
● Implemented the Dementia FaNS (Friends and Neighbours) network wishing washing line to help bring people's wishes true
● They were currently looking into Wheels for All, national accessible cycling charity to people the opportunity to cycle.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment You are failing to robustly assess the risks relating to the health, safety and welfare of people using the service. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Failure to have systems in place to recognise and protect people from unnecessary control and restraint, including the excessive or inappropriate use of medicines placed people at risk of harm. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance You are failing to have robust systems and processes in place to assess, monitor, and

improve the quality and safety of the service.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment You are failing to ensure the proper and safe management of medicines. Failure to identify and address issues relating medicines presented a potential risk to the health and welfare of service users. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

Warning notice