Jeesal Residential Care Services Limited

Westbrook House

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
Westbrook House is a residential care home providing personal care to people with a learning disability and/or autistic people. The service can support up to seven people. At the time of the inspection there were five people living in the home. Westbrook House is a terraced house set over four floors.

People's experience of using this service and what we found
People living in the service had been exposed to risk of harm. Risks relating to numerous areas including the environment had been poorly assessed and responded to. Safeguarding systems were ineffective and exposed people to risk of abuse. Incidents were not always reported and when incidents occurred staff did not take effective actions to mitigate risks. People were exposed to an increased risk of infection, this included in relation to COVID-19. Staffing was poorly managed, and this impacted on the ability of staff, including managers, to carry out their roles. Medicines were not being safely managed.

People were not being supported by staff who had the correct skills and training. Best practice guidance and legislation was not being applied. The environment had been poorly maintained and was dirty. People were living in dirty bedrooms with mould and damp. Staff were not supporting people in the service to eat healthily and in some cases people's individual needs around their diet were not met. Staff were not proactive in managing or responding to people's healthcare 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; the policies and systems in the service did not support this practice.

The dirty poorly maintained environment was not respectful and did not promote their dignity. People were not supported by staff who paid attention to their needs and ensured these were met. Staff did not always treat people with respect. People's rights were not fully protected and as a result their property and finances were not always treated respectfully. Staff were not effectively utilising the systems in place to ensure people were fully involved in their care.

The support provided had not adequately met people's needs or been provided in a timely manner. A lack of person-centred planning meant people's needs were not considered and met, this was across a wide range of areas including social contact and recreational activities. Staff were not utilising communication systems to ensure people's communication needs were met.

There was a lack of leadership and management in the service. There had been no registered manager in post since April 2020. Staff spoke about poor communication and support which hampered their ability to meet people's needs. Governance systems were ineffective and where issues had been identified action to drive improvement had not taken place. The incident reporting and monitoring system was ineffective, and incidents had not been reported where required including to CQC.

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.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. The model of care being followed did not maximise people's choice, control and independence. The care was not person-centred and did not promote people's dignity and human rights. There was a lack of person-centred culture and values within the service. These concerns had contributed to people's individual needs not being met and being placed at risk of harm. The issues identified during the inspection were discussed with the provider. The provider told us they had recognised and identified widespread failings in the service and the poorly maintained environment prior to our inspection. They told us given the extent and nature of the concerns they had identified that the best course of action would be to close the service. At the time of our inspection the provider was working with the local authority to identify alternative placements for people so the service could be closed as soon as reasonably possible.

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 07 March 2019)

Why we inspected
The inspection was prompted in part due to concerns received about the management of the service, governance and oversight, safe care and improper treatment of service users, and environmental concerns. A decision was made for us to carry out a comprehensive inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person-centred care, dignity and respect, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, premises and equipment, staffing, good governance, notification of incidents, and there being no registered manager.

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
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 effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not caring.

Details are in our caring findings below.

Inadequate

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Westbrook House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by two inspectors.

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

The service should have a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. No registered manager had been in post since April 2020.

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 took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with the nominated individual, the nominated individual is responsible for supervising the management of the service on behalf of the provider, and nine members of staff. This included, the acting covering manager, the deputy manager, the service support manager, the community service development manager, and six care staff. Not everyone using the service could provide verbal feedback on the care provided, therefore we carried out observations of people's care to help us understand people's experiences.

We reviewed a range of records. This included fives people's care records and four people's medication records. A variety of records relating to the management of the service, including audits and records relating to health and safety were reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- The systems in place had not operated effectively to ensure abuse was reported and action taken in response. We identified a serious incident that had occurred in April 2021 that should have been reported to external safeguarding agencies. Following our inspection, we raised a safeguarding alert about this as well as other concerns identified during our inspection.
- The incident in April 2021 raised concerns about the conduct of staff involved in the incident. We also identified behaviour from other staff members that amounted to abusive and improper treatment.
- During our inspection we identified a number of occasions where people were not safeguarded in relation to their human rights or in relation to their finances and property.

People had not been protected from abuse and improper treatment. Systems and processes were not operated effectively to prevent or investigate allegations of abuse. This was a breach of regulation 13 (Safeguarding service user from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Risks were not assessed, and actions were not taken to mitigate risk. This meant people had been exposed to avoidable harm.
- Risks relating to the environment were not mitigated. Fire safety checks had not been carried out and fire doors in the service were in poor condition. During our inspection we identified fire safety concerns with an appliance that was in use. Exposed radiators and pipes were found throughout the building which posed a risk of entrapment and burns when in use.
- The environment was in a poor state of repair. There were holes in walls and the deputy manager told us the lift had been out of use for three years. A risk assessment regarding asbestos stated this was known to be in the building but the risk to people, particularly considering the damage to the fabric of the building, had not been considered or assessed.
- The service was across four floors with some people's bedrooms on the first and second floors. Some people with bedrooms on these floors had health conditions which may have been exacerbated by the use of stairs. No assessments of these risks or mitigating actions had been carried out.
- Risks across a wide range of areas had not been assessed, this included in relation to people's skin integrity, mobility, and distressed behaviours. This meant staff were not clear about how to respond and manage these risks.
- Where risks were identified the systems in place to monitor them was not robust. This meant actions to mitigate these risks were not considered. For example, some people required specific charts to help assess episodes of distress, but these were not being accurately completed.

● When incidents had occurred in the service these had not been used to inform learning and review risks. For example, where falls had occurred no risk assessments had been carried out or amendments to support plans made.
● Staff told us that a lack of communication and lack of structured support hampered their efforts to manage risk. One staff member said, "It just seems half the time staff are coming up with these plans we just feel we get ignored. Sometimes I don't feel we are taken seriously."

People had been exposed to avoidable harm. Risks had not been assessed or mitigated. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People were living in unclean conditions that increased the risk of infection. Mould and damp were found throughout the service, including in people's bedrooms. Living with mould and damp increased the risk of respiratory infections. Some people living in the service suffered from respiratory conditions which meant the exposure to damp and mould could make these conditions worse.
● The environment was unclean which increased the risk of infection. Cleaning records did not evidence regular cleaning and had not been reviewed or increased, for example to cover high risk surface areas such as door handles or light switches, in recognition of the increased risk posed by COVID-19.
● Risks regarding COVID-19 were not well managed. There were no designated areas for putting on or disposing of personal protective equipment (PPE). The deputy manager told us they normally left the service with their PPE.
● People were being supported to visit some of the provider's other services, but the deputy manager told us they could not confidently say that people were being supported to test for COVID-19 before each visit. No records of this taking place were held, and no risk assessments regarding this were in place.
● During our inspection visits we observed staff taking lateral flow COVID-19 tests prior to starting their shift but not waiting the full 30 minutes for the test result before starting to work on the floor. This is important and part of government guidance as a positive test result can appear any time after 20 minutes and a negative may take as long as 30 minutes to appear.

People were not protected from the risk of infections. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were not deployed in a manner which took in to account their skills and experience. The deputy manager told us they were not provided with information about agency staff from the provider. They said this meant agency staffs skills and experience weren't known to them and they couldn't take this into account when organising the rotas.
● Rotas showed agency staff were allocated to provide one to one support to people who experienced frequent occasions of emotional distress. Training information for these staff showed they did not have the training in areas that the provider had deemed mandatory to work in the service. A staff member told us, "A lot of agency staff query why are they with [service user] without the training, a lot of them come from nursing homes and don't have NAPPI level 1" (non-abusive psychological and physical intervention training).
● Staffing levels and staff sickness were impacting on the running of the service. A staff member told us, "The staffing levels especially the one-to-one have been really stressful, when you are doing them you are not going to get your paperwork done". Another staff member said, "There is a lot of people [staff] that seem to call in sick on a whim. That's something that happens a lot throughout the time I have been there we've

been left short because people [staff] just don't want to come in."
● At both our inspection visits we noted that the management staff were working on the floor delivering direct care. Both the deputy manager and service support manager told us that staffing levels were impacting on their ability to carry out their managerial tasks.

Sufficient numbers of suitably qualified and skilled staff were not deployed. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● The medicine management system in place could not demonstrate people had received their medicines as prescribed.
● The medicines management records for three people showed medicines were not recorded as given as prescribed. These gaps had not been identified or reported by staff. This meant no action had been taken by staff to investigate these gaps and assure themselves the medicines had been administered.
● In one instance staff had not acted proactively or in a timely manner to support an assessment of any negative impact from one person's prescribed medicines.
● There was no system in place to ensure medicines were being managed safely and errors identified and explored. The deputy manager told us no medicine audits had taken place since December 2020.

Medicines were not being managed safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Staff support: induction, training, skills and experience

- The provider's agency profile requirements stated that agency staff must have had training in Non-Abusive Psychological and Physical Intervention (NAPPI) level 1. NAPPI training is accredited with the Restraint Reduction Network Training Standards and designed to train staff in positive behaviour support and how to avoid the presence and escalation of expressions of distressed behaviour. The provider's policy stated staff without the required training might be used as long as the training was delivered within four weeks of working at the service.
- The eight agency staff working at the service did not have this training. They were being allocated to provide direct one-to-one support to people in the service who experienced frequent episodes of distress and had been working at the service for longer than four weeks.
- The training matrix showed that NAPPI level 1 training had expired for eight out of the 14 permanent staff working in the service.
- The staff training compliance showed on overall training compliance at the service was only 60.4%. Of the 14 staff listed on the training compliance record only 3 had a training compliance level above 80%. Two staff still working on shifts had a training compliance of 20% and 25%.
- Our observations, discussions with staff, and findings at our inspection demonstrated a lack of knowledge and competence amongst the staff team. This compromised their ability to carry out their role and support staff according to best practice guidance and legislation.

Sufficient numbers of suitably qualified and skilled staff were not deployed. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The environment was not clean. Areas such as communal hallways, bathrooms, and kitchen were unclean, with dust and dirt. We noticed people were sitting on stained and dirty furniture. It was not evident that cleaning was regularly taking place and cleaning records showed gaps. This was raised with the provider following our first visit on the 22 June. The provider told us they would arrange for a deep clean of the service. On our return visit on 5 July we found no improvement. A staff member told us, "It's one of those places you can clean it as much as you can but you're never going to make it look presentable really."
- The environment was not properly maintained. We identified damage to walls, some of which exposed the wall cavity, mould and damp. The deputy manager told us the lift had been out of use for three years and we identified several people who would have benefited from its use due to mobility or health concerns.

The premises were not clean or properly maintained this was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● The support people required around their eating had not been fully assessed and support plans did not provide enough guidance for staff on how to meet these needs.
●Some people living in the service required support with healthy eating. Support plans did not provide sufficient information for staff on how to support people with this. People were not being supported to weigh themselves regularly to help inform healthy eating choices and food records for people requiring this support did not evidence this support was being provided.
● Some people in the service also had specific care plans in place following a speech and language therapist assessment. Food records showed these care plans were not always being followed.
● Systems in place to monitor people's food and fluid intake were not effective as staff were not recording people's intake consistently and there was no system in place to review the intakes and identify concerns.

People's nutritional needs were not being met. This was a breach of regulation 14 (meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff were not proactive in following up people's health appointments and ensuring these needs were met. We found delays in actioning and seeking advice from relevant health care professionals for two people.
● People's oral health needs were not assessed. This had resulted in staff being unclear on how two people's oral health should be supported and met.

People's health needs were not being met. This was a breach of regulation 9 (person-centred care) 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
● Assessments of people's current needs had not been carried out. The management team told us that support plans were out of date. The support plans we reviewed did not provide enough information and guidance for staff on how to meet people's needs. A staff member told us, "It [support plans] didn't really tell me much, a lot of it is picked up tips from other staff members."
● Staff did not support people in accordance with best practice guidance and current legislation in areas such as communication, skin integrity, and restrictive practices.

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.

● Mental capacity assessments had not been carried out in line with the MCA code of practice. For example, no mental capacity assessments had been carried out in relation to regular COVID-19 testing.
● Staff were making decisions on purchasing items for people who did not have capacity to agree to this without following or recording any best interests process.
● Some people had restrictions in place, such as movement sensors, but no mental capacity assessments or best interest decisions to ensure these were appropriate had been carried out.
● One person's DoLS had expired the deputy manager told us they had not applied to renew this as they expected the person to move from the service in due course. This is not in line with the MCA code of practice.

The service was not acting in accordance with the MCA and the code of practice. This was a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were living in dirty poorly maintained environment that was not respectful and did not promote their dignity.
- There was a lack of attention to people's needs which did not promote their privacy or dignity. For example, in one person's bedroom their curtains were hanging off the curtain rail on both inspection visits. Another person showed us an item that belonged to them which was not working, we raised this with staff on two occasions prior to our return visit on 5 July. Both told us the person really enjoyed using the item and the batteries probably needed replacing. At our visit on 5 July, we found this item was not still working.
- The provider had not ensured systems to support and protect people's rights were effective and being used. This meant people's rights were not fully protected and as a result their property and finances were not always treated respectfully. For example, staff were purchasing items out of people's own money, including their own birthday presents, and using people's own items for communal use.
- We observed some staff behaviour that was not respectful and did not promote people's dignity. This included staff talking about people in front of them or referring to them in a disrespectful manner.

People were not treated with dignity and respect. This was a breach of regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Systems in place designed to facilitate people's engagement and decision making about their care were not being operated effectively. A system was in place whereby staff supported people to discuss monthly plans and goals. These were not regularly taking place.
- The deputy manager told us people were supported to have input in to and be involved in their care and support through monthly reviews of their care. The deputy manager told us these had not always taken place. Our review of these records confirmed this.
- The lack of proactive engagement with health professionals meant this also limited information and support available to staff and people in making decisions around their care.
- The lack of adherence to the MCA meant that people and those involved in particular aspects of their care, were not provided with opportunities to support the care provided and have input into decision making.

People and other relevant persons were not supported to engage in assessments or decision making regarding their care. This was a breach of regulation 9 (person-centred care) of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

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; Meeting people's communication needs

- The support provided had not adequately met people's needs or in a timely manner. For example, in relation to people's health conditions, fluid and hydration, and consent.
- There was a lack of person-centred planning which meant people's needs were not always met. Whilst staff were trying this was in an ad hoc way as they lacked support and direction. One staff member told us, "What I know about a tenant, what they like and don't like, none of that is in pandora [electronic care system] to be able to care for a person you need to know that."
- Many of the support plans that were in place were out of date and did not accurately reflect people's needs. People's needs in relation to their recorded faiths were not explored and staff, when we discussed this with them, were not clear on the importance of people's faiths to them.

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

- People's communication needs were not assessed in detail and support plans did not provide enough information in this area. Staff were not aware of different communication strategies that might support people with their communication.
- We found one person had been assessed by a speech and language therapist who had recommended to staff a plan and actions to aid communication with the person. We found this plan and not been actioned and observed staff interacting with the person in way that did not follow this guidance.

The support provided did not meet people's needs. This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- No formal support planning had taken place to identify people's needs, interests and activities that might be culturally relevant to them. Whilst people had individual support plans around certain activities, such as going for a walk, it was not clear how this activity had been selected and informed by people's needs.
- This has meant there was a lack of meaningful planned activity that considered people's needs and preferences. For example, people with sensory impairments in the service had no clear activities plan that addressed this in a meaningful way. Whilst some staff told us about sensory activities they provided to

support this need, these activities did not have associated support planning. As such they were being delivered in an ad hoc way without being fully considered or planned.
● Each person had an activities timetable in place, but we observed these were not being carried out. A staff member told us these were not used they said, "It was like working with the impossible". We observed limited meaningful interaction and activities for those people living in the service who had more complex needs. During our first inspection visit we observed two people sitting on a sofa in a dining room not engaged in any activity for much of the day.

Care and support was not designed in order to meet people's preferences and needs. This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● We reviewed the service's complaints file and noted the last complaint recorded was 2017.
● We had received several whistle-blowing concerns regarding the service in March and April 2021, these concerns were shared with the provider and assurances sought on how these were being addressed. We identified similar concerns during our inspection which meant we were not confident the service was effectively learning from concerns to help address and improve areas of concern.

End of life care and support
● No one at the service was being supported at the end of their life. There were no support plans in place regarding people's end of life wishes or what arrangements might have been made or required following their death.
●Some people living in the service had specific religious faiths recorded but no support planning on how this might impact people's care at the end of life had been carried out.

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

- A person-centred culture was not being promoted. Principles of person-centred care planning and support were not evident, and people's needs were not being met. Equality characteristics had not been fully considered or planned for.
- Systems to engage and involve people in the service were not being used effectively and this also contributed to a poor person-centred culture.
- Whilst individual staff were trying to meet people's individual needs there was a lack of communication, support, and effective systems to support them. This hampered staff member's ability to meet people's needs.
- Staff we spoke with told us information was limited and communication poor. One staff member said, "We're supposed to have handovers, but they are hit and miss, probably had two since I've worked here." Another staff member told us, "Communication in the company is terrible."
- Only two staff meetings had been held in 2021. The last staff meeting had been in April, the minutes for which showed some staff raising concerns and providing feedback. Staff we spoke with told us they had had no response following this and we found issues raised had not been addressed at the time of the inspection. One staff member said, "It's disheartening. There are a lot of members of staff there at the moment who are frustrated."

Systems to seek and act on feedback, and to evaluate and improve practice were not effective. This was not regularly taking place in a meaningful way. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- There was a lack of clear and effective governance systems that identified and addressed areas of concern. Limited audits were taking place and when these were carried out, they had failed to ensure standards of care and regulatory requirements were met. We identified numerous failings across the service that placed people at risk of harm.
- Timely and effective action had not been taken to make improvements when these had been identified as required. Staff meeting minutes in April 2021 and the provider's own internal inspection in February had identified issues such as poor support plans and training compliance but we found no improvements had

been made at our inspection.
● Records relating to people's care and support were not kept up to date or complete. This is a regulatory requirement.
● The incident reporting and monitoring system was ineffective as incidents were not always identified or reported using this system. This meant oversight of risk and identification of areas for improvement was not robust.
● Where incidents were recorded on this system, they did not help improve the quality and safety of the service provided or stimulate lessons learnt. The deputy manager told us that no analysis or review of incidents took place within the service. Staff told us incidents were not discussed and used as opportunities to learn lessons and improve the support provided.

Quality monitoring systems were ineffective in monitoring and improving the quality of the service. The systems in place had failed to identify, monitor and mitigate concerns within the service which placed people at risk of harm. This meant the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had had no registered manager since April 2020. This meant the provider had not met conditions of their registration. The deputy manager was undertaking the day to day running of the service but was also working on shifts providing direct care and support. This had compromised the effectiveness of the management of the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
●We identified safeguarding incidents that had not always been reported both internally and to external relevant parties, including CQC. This meant we were unable to have a full oversight of the service including any concerns.
● The issues identified with the reporting of incidents meant we could not be confident that duty of candour was always met.

Failure to notify CQC of safeguarding incidents was a breach of Regulation 18 (notification of other incidents) Care Quality Commission (Registration) Regulations 2009.

Working in partnership with others
● Partnership working with other professionals was reactive rather than proactive. We identified incidents where staff had not taken timely action in seeking to work collaboratively with other professionals.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met: The service had failed to notify CQC of safeguarding incidents