Achieve Together Limited

78 Stubbington Lane

Inspection report

78 Stubbington Lane
Stubbington
Portsmouth, Hampshire
PO14 2PE

Tel: 01329668701
Website: www.achievetogether.co.uk

Date of inspection visit:
19 May 2023
22 May 2023
25 May 2023

Date of publication:
18 July 2023

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
78 Stubbington Lane is a small residential care home providing personal care to up to 6 people. The service provides support to people who live with learning disabilities and autistic people. At the time of our inspection there were 6 people using the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support
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. For example, people had not been involved in developing their support plans and were not involved in reviews about their care. Where people lacked capacity to make choices the principles for the Mental Capacity Act (MCA) were not always followed. People did have privacy for themselves and their visitors, and the service was in a location where people could participate in their local community

Right Care
Care was not fully person-centred. For example, staff did not always know people well. People were not always treated with dignity and respect and care plans were not always person centred. We have made a recommendation about this.

Right Culture
Leaders and care staff did not fully ensure people using services led confident, inclusive, and empowered lives. It was not clear how people had been empowered to have as much choice and control over their care as possible.

Risks to people's health and wellbeing had not been monitored or mitigated effectively.

People were at risk of harm because staff did not always have the information they needed, to support people safely. Medicines were not always managed safely.

People did not receive a service that provided them with safe, effective, compassionate, and high-quality care. The provider had not established an effective system to ensure people were protected from the risk of abuse. A lack of timely action by leaders to ensure safeguarding incidents were reported meant CQC and

the local authority did not have the information required to monitor the safety of the people using the service. Some staff did not always have a good understanding of safeguarding, they did not always recognise safeguarding concerns or highlight them to the management team. This meant safeguarding concerns had not always been referred to the local authority and notified to CQC.

People were not always involved in decisions about their care. We have made a recommendation about this.

The Accessible Information Standard (AIS) was not always followed. We have made a recommendation about this.

Leadership at the service had been poor until recently, and the service was not well-led. Governance systems were not always effective and did not always identify the risks to the health, safety, and well-being of people. The regional manager had set up an action plan to make improvements.

The provider did not always have enough oversight of the service to ensure that it was being managed safely and that quality was maintained. Quality assurance processes had not identified all of the concerns in the service and where they had, sufficient improvement had not always taken place. Records were not always complete. People and stakeholders were not always given the opportunity to feedback about care or the wider service. This meant people did not always receive high-quality care. The provider had identified these areas of concern and was taking action to ensure good governance.

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

Rating at last inspection
This service was registered with us on 1 December 2020 under a new legal entity, and this is the first inspection under this provider.

The last rating for the service under the previous provider was good, published on 4 February 2020.

Why we inspected
The inspection was prompted in part due to concerns received about medicines management, the cleanliness of the environment and lack of suitably trained staff. A decision was made for us to inspect and examine those risks.

The provider had taken action to mitigate some of the risks.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to assessing risk, medicines management, safeguarding, the Mental Capacity Act (MCA), person centred care, training, managing feedback, management oversight and failure to notify CQC of required incidents at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 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 always well-led. Details are in our well-led findings below.	**Requires Improvement**

78 Stubbington Lane

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.

Service and service type
78 Stubbington Lane is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under 1 contractual agreement dependent on their registration with us. 78 Stubbington Lane is a care home without 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 not a registered manager in post. A new manager started work at 78 Stubbington Lane during our inspection. They intend to apply to become the registered manager.

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 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 spoke with 3 people who used the service and received feedback from 4 relatives about their experience of the care provided. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including medicines management, policies and procedures were also reviewed. We spoke with 4 members of staff including the regional manager and 3 care workers. We also spoke to a consultant employed by the service and 1 visiting professional.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The provider failed to ensure the safety of people. Risks to people were not managed and mitigated effectively.
- Although risk assessments were in place for some risks, they did not always contain enough information to guide staff on how to mitigate and manage the risks relating to people's needs. Other risks did not always have a risk assessment in place.
- For example, we observed a mealtime, 1 person was overloading their mouth with food and was coughing while eating. A member of care staff was sat at the table with people but did not offer any advice to the person to slow down or to take smaller mouthfuls. There was a risk assessment in place in relation to this person's potential risk of choking, however, it had not been reviewed and the only information it contained was to say the person could eat too quickly and, "Staff need to engage with [person] to get them to slow down when rushing." This meant we could not be assured people's needs were assessed and monitored effectively.
- Following a discussion with the regional manager, a Speech and Language Therapy (SaLT) referral was made, and the risk management plan was updated. The regional manager had instructed consultants to support them with reviewing and updating all documentation within the service prior to the inspection.
- People who had medical conditions did not always have a care plan or risk assessment in place to guide staff how to support them with these conditions. For example, 1 person had high blood pressure, however, there was no detail of how to support this person with this condition or of the signs to look out for.
- We asked staff if anyone had high blood pressure, their comments included, "No, they don't. I would look out for light headedness, red in face, disorientation, or nausea," and, "Not that I know of. None have high blood pressure medication."
- People's health conditions were not always considered. For example, 1 person had a condition which meant they should reduce the amount of carbohydrate they had, however, their meal on the day on inspection included a wrap and chips. This meant there was a risk their health condition could be adversely affected.
- One person's records indicated they had put on 12 kilograms in the last year. The care plan stated, "If we see an increase then we will need to look into what is happening and seek external support." There was no evidence any support had been sought. This meant there was a risk underlying health conditions may not be picked up.
- A care plan for 1 person talked about physical interventions, however, staff told us they had not had training to carry out physical interventions. Their comments included, "I read that [person's name] does have interventions, but we are not trained in [physical interventions]", "I did [training] years ago, nothing recent," and, "We haven't had bespoke training as the guys we look after are low level with their behaviours, so we are just given the basics to keep people safe."

● People had personal emergency evacuation plans in place (PEEPS) however, the night-time evacuation plan guided staff to support all 6 people individually to put on their shoes and coats as well as accessing items to support people to reduce anxiety. For example, the PEEPS suggested a can of coke should be taken out for 3 people, teddies for 2 people and a handbag for another person. These items were not in the grab bag which meant if staff were to follow the plan there was a risk, they would not exit the building in a timely way putting people at risk of serious harm. We spoke to the regional manager about this. They reviewed and updated the PEEPS during the inspection.
● We observed a cupboard under the sink in the kitchen which was labelled, 'Control of Substances Hazardous to Health (COSSH) Store.' This cupboard was unlocked and contained cleaning liquids. The manager told us, "It should be locked." There were risks people could be harmed if they accessed this cupboard and its contents. The labels suggested the risks had been considered, however, staff failed to ensure processes were adhered to and the door was locked. The manager set up a new COSHH cupboard and process to mitigate the risk of this occurring again in the future.
● There was a freezer in the dining room which had a notice on it which stated, "Do not store raw meat in this freezer." Raw meat was being stored in the freezer on top of bread and other items. There was a risk other food could become contaminated with juices of raw meat, this put people at risk of harm. The regional manager moved the meat to another freezer. Although the risk had been assessed staff were not following guidance to ensure people remained safe.

The failure to ensure people were provided with safe care and treatment and risks were assessed, monitored, and mitigated was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not always managed safely. People who were prescribed 'as required' (PRN) medicines had a PRN protocol in place to guide staff when and how to use these medicines. However, these did not always contain the correct information. For example, 1 person was prescribed pain medicine as an oral suspension, however, the PRN protocol in place to guide staff, related to the medicine in tablet form, the instructions for which are different to the instructions for the oral medicine. This meant guidance was not in place to guide staff how and when to give the oral suspension.
● One person had a medicated toothpaste which was not on the MAR chart. This meant we could not be sure it was still prescribed and should still be used.
● Another person was prescribed PRN paracetamol, 2 to be taken 4 times a day when required, however, their PRN protocol stated, 'take 1 or 2 tablets up to 4 times a day.)' This was different to their prescription. The PRN protocol stated, 'minimum period between doses 12 hours,' their MAR stated, 'Take 2, 4 times a day when required. This meant the person may not receive enough medicine to relieve their pain.
● There was no PRN protocol in place for medicated creams. There were no risk assessments in place for the safe management of flammable creams.
● Medicines Administration Records (MAR) charts were not always signed to evidence if medicines had been administered. This meant there was a risk people were not having their medicines administered as prescribed or were at risk of having medicines administered again if they had been given and not signed for.

The failure to ensure safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes in place to safeguard people from abuse were not effective.
● Where safeguarding incidents had occurred, for example, people hitting each other, a referral had not

always been made to the safeguarding team.
● The regional manager had reviewed safeguarding and CQC notifications prior to the inspection and had informed us of some incidents where referrals and CQC notifications had not been made. They made retrospective referrals and notifications for these.
● During the inspection we identified a further 3 notifiable incidents which had occurred and had not been referred to safeguarding or notified to CQC. Not all staff had received safeguarding training.
● Staff told us they would report any abuse to the manager; however, this did not always happen.
● We spoke to the regional manager about this who told us she was not aware these incidents had taken place. This meant the local authority safeguarding team and CQC were not being kept informed of these incidents and were unable to monitor the service effectively.

The failure to establish systems and processes and operate them effectively to prevent abuse of service users was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the regional manager made retrospective safeguarding referrals and CQC notifications for the 3 reportable incidents found on inspection.

Staffing and recruitment
● Staffing levels were adequate, however, the service used a lot of agency staff who were not always trained to the level required to support people safely, for example, administering epilepsy rescue medicines and regular medicines.
● The provider's training records evidenced not all staff had received adequate training in a timely way to equip them to carry out their roles safely and effectively. For example, some gaps were noted in the completion of fire safety awareness, health and safety training, moving, and handling training and specific physical intervention training. Staff confirmed they had not received all of the training they required.
● Staff told us they had not received training in physical interventions. However, risk management plans talked about physical interventions being used. For example, 1 risk management plan stated, "Use the least restrictive physical intervention that is proportionate and reasonable to the level of aggression being presented." This meant staff were not trained to follow the risk management plan which could put people and staff at serious risk of harm.
● From our observations and conversations with staff it was evident staff wanted to provide safe and effective care to people, however, they sometimes lacked the skills, knowledge and understanding of people's needs and how to manage those needs safely and appropriately.
● A staff member told us, "There is not enough trained staff."

The failure to ensure persons providing care to service users have the qualifications, competence, skills, and experience to do so safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Complete recruitment documentation was not available in the service; however, recruitment policies and procedures were in place to ensure staff were recruited safely. Following the inspection, the regional manager sent us evidence to demonstrate appropriate pre-employment checks were completed.

Learning lessons when things go wrong
● We could not be assured lessons were learned when things went wrong. Until recently there was no manager in place. The regional manager had only been in post for almost 3 months. Risk assessments and care plans were not reviewed following incidents and accidents to prevent reoccurrence. This was because

the regional manager had not always been informed incidents had taken place.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People told us they had visitors who came to the service. The manager told us visitors were welcome and relatives told us they could visit when they wanted. Visiting was managed in line with current guidance.

Requires Improvement

Is the service effective?

Our findings

Our findings - Is the service effective? = Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated 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 provider was not always working in line with the principles of the MCA.
- Where people lacked capacity to consent, mental capacity assessments had been completed for specific decisions and where capacity assessments had taken place there was a recorded best interest decision.
- However, 2 people were observed at all times while they were in their bedroom through video and audio monitoring equipment. There was not a clear rationale for this level of monitoring. We spoke to the regional manager about this who told us they were going to be looking into systems which would be less restrictive.
- All people living at the home were under continuous supervision and control. However, this was contradicted in people's risk management plans. For example, some people's risk management plans stated, "[Person] is not under a Mental Health Act Section nor any other legal requirement that would impede them from making an unwise choice and going out without trained support, or the support of someone who knows their needs." However, staff told us there was no one who could go out on their own.
- Most relatives told us they had not been involved in mental capacity assessments and best interest decisions.
- We asked staff about their understanding of the MCA, 1 staff member told us, "A hard one. I haven't had a

lot of training in this. It's the guys having the mental capacity and having best interests' meetings."
● The regional manager told us some people had DoLS authorisations in place and the others had been applied for, however, we had not been provided with any evidence at the time of writing this report.
● Staff did not always understand what a DoLS was. Staff comments included, "Deprivation of liberty. I know they get put in place for certain things. One is in place for falls. I haven't done any training for quite a while" and, "Deprivation of liberties, it can be used if you have a profiling bed with bed rails because you are restricting them. I don't think anyone at present has any specific DOLS at this point." This meant staff did not have a sound knowledge of DoLS which could lead to staff either restricting people unnecessarily or may not deprive someone of their liberty when this had been legally authorised, putting people at risk of harm.
● Some family members managed people's finances. We could not be assured all people whose finances were managed by their families had Lasting Power of Attorney (LPA) documentation available or an appointee in place. If you are unable to manage your own affairs, an LPA is a legally appointed person, who is someone of your choice, to do it for you. We asked the provider for evidence of any LPA; however, this had not been provided at the time of writing this report. An appointee is responsible for making and maintaining any benefit claims.

The failure to act in accordance with the MCA was a breach of Regulation 11 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
● People's needs were assessed before they moved into the home. However, care plans and risk assessments were not regularly reviewed and updated when people's needs changed, were over a year old, and had not been signed by the author. This meant staff did not have the up-to-date information required to enable them to provide people with good person-centred effective care.
● Documents told us 3 people required prescription glasses. The regional manager was not aware 2 of the people required glasses. Records did not identify which optician these people went to which meant the regional manager could not check if glasses had been provided. The regional manager told us they would make new optician appointments for all 3 people.
● People and their relatives had not been involved in developing their support plans and risk assessments which meant their needs and choices were not always considered.
● There was evidence care plans had not been written for individual people. For example, some wording had been copied and pasted and some care plans contained other people's names. Care plans also referred to people as him and her inconsistently throughout. This meant care plans were not centred specifically around individual people.
● Care plans we reviewed stated all people were at risk of opening the car door while the vehicle was in motion, despite the fact for most people this had not occurred and was not an assessed risk. This meant care plans and risk assessments were not person centred.

The failure to ensure people were provided with person-centred care was a breach of Regulation 9 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
● People were not always supported to access healthcare services in a timely way. For example, we observed 1 person coughing while eating and putting too much food in their mouth. A SaLT referral had not been made for this person. This meant this person was at risk of harm due to the potential risk of choking. We spoke to the regional manager about this. They immediately made a referral to the speech and language therapy team.

● Another person had lost a significant amount of weight. A visiting professional told us this had not been picked up immediately, and when it was, weights were not recorded weekly as requested by the professional. Records confirmed weight was recorded monthly. The regional manager told us they would ensure this was done weekly going forward.
● People had been supported to access the dentist and have treatment where required.

Supporting people to eat and drink enough to maintain a balanced diet
● The people we spoke to told us they liked the food, 1 person said, "Yes, [likes the food], the staff do the menu."
● However, we could not be assured people were always supported to eat a varied and nutritious diet. On the first day of the inspection, people had a chicken sandwich, sausage roll, crisps, and a yoghurt for lunch. People ate different things for their evening meal, we observed 1 person had pizza and garlic bread, another had a fishfinger sandwich, crisps, and garlic bread and a third person had a chicken and tomato wrap with chips. The regional manager told us they had picked up on this and were reviewing the menu to offer healthier choices.
● We observed 1 person had a drink, we asked another person if they would normally have a drink and they replied, "No." After this they did ask a staff member for a drink, a third person told us they had forgotten to make themselves a drink and went off to make one.
● Mealtime was not a positive dining experience. There were table mats on the table; however, there were no condiments. One person asked us to get them some mayonnaise and soy sauce. We spoke to the regional manager about this. They told us they would review mealtimes and introduce condiments on the table for people at mealtimes.

Staff support: induction, training, skills, and experience
● The provider's training records evidenced not all staff had received adequate training in a timely way to equip them to carry out their roles safely and effectively. We have reported on this in the safe key question of this report.
● We also found gaps in dignity and respect training and person-centred care training.
● The regional manager was aware training was out of date and told us they were working to improve the training statistics and, "a lot of the training that is outstanding is in the process of being booked."
● Staff had not been receiving regular supervision and team meetings however, the new manager had already started planning supervisions and had held a team meeting during his first week.
● Staff told us they felt positive they had a new manager.

Adapting service, design, decoration to meet people's needs
● The service was not fully adapted, designed, and decorated to meet people's needs. Some repairs were required, for example, enamel had come off the bath in the bathroom which led to rusting. The bin in the bathroom was rusty. This made it difficult to keep these areas clean which was an infection prevention and control risk.
● The kitchen was old and in a state of disrepair. This had been identified by the regional manager who told us the kitchen and bathrooms were being replaced soon.
● People had personalised bedrooms; window restrictors were in place where required. People told us they liked their bedrooms.
● The regional manager told us they would provide us with the home improvement plan for the service; however, this had not been received at the time of writing this report.

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.

This is the first inspection for this newly registered service. This key question has been rated 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; Supporting people to express their views and be involved in making decisions about their care

- People were not always treated well and supported. We have reported more about this in the safe question of this report.
- Although we did see kind interactions by some staff, most of the interactions observed were task focussed. For example, staff spoke to people when they wanted them to do something, however, there was little interaction at other times and people were not occupied.
- A relative told us most of the old staff had left and there was a new staff team in place. They told us the new staff were going to have to learn about people's needs. They said, "Shame we lost some very experienced staff."
- There was no evidence in people's records that people or their relatives had been involved in developing them or been involved in reviews, because these had not always taken place. People and their relatives were not always supported to express their views. This meant they were not always involved in decisions about their care.

We recommend the provider seek advice and current guidance from a reputable source about involving people in decisions about their care and support and update their practice accordingly.

Respecting and promoting people's privacy, dignity, and independence

- People were not always treated with dignity. We observed 1 staff member when the meal was ready, standing in the kitchen and shouting people's names loudly.
- People's privacy was not always respected due to the use of video and audio equipment in 2 people's bedrooms, we could not see any evidence that less restrictive practices had been considered. The regional manager told us they would be reviewing this practice.
- Relatives and staff told us they were hopeful things were improving with the appointment of a new manager who started at the service on the second day of our inspection.

We recommend the provider seeks current guidance on how to ensure staff treat people with dignity and update their practice accordingly.

- Care files and confidential information about people was stored securely and only accessible by authorised staff when needed. This demonstrated people's confidential information had been stored appropriately in accordance with legislation.

● Staff told us how they maintained people's privacy and dignity when providing personal care. They told us they knocked on people's doors and ensured curtains and doors were closed when appropriate.
● Most relatives told us they thought people were treated with dignity and respect.
● Relatives consistently told us they thought the staff were caring.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

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.

- Not all people could read, however, menus were written down. This meant some people could not understand what was on the menu and were unable to go and check what the next meal was if they wanted to.
- We read in people's records, "[Person] has access to easy read safeguarding information in the lounge." However, this information was not available in the lounge. We did notice an easy read safeguarding guide in the hall however, not all people were able to understand this document and there was no evidence this had been shared with people or how they were supported to understand it.

We recommend the provider seeks guidance and best practice information how to communicate effectively with people and update their practice accordingly.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans were not always personalised, and some contained other people's names in them.
- Care plans were not always reviewed and revised as people's needs changed.
- Staff received a verbal handover between each shift. This helped inform staff of any changes in people's needs.
- We saw some evidence people were encouraged to make their own decisions and choices where possible. For example, what time they liked to get up, and go to bed. We also saw evidence 1 person preferred to have a female staff member to support them with personal care.
- Staff were not always knowledgeable about people's preferences and care needs. This has been talked about more under the effective question of this report.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not always supported to go out and participate in activities because this was dependant on having the right number of trained staff on duty.
- Relatives comments included, "Where they haven't had staff [person] hasn't been able to go anywhere, they are not getting all the care they previously had. It has gone downhill bad", "I don't think they do

anything at the moment, they haven't had a driver to take them out. They do nothing much."
● When enough appropriately trained staff were on duty people were supported to go out to places such as the beach, the New Forest, cinema, and bowling.
● People who had relatives were supported to see them on a regular basis. A relative told us, "This home is very kind because they bring [person's name] to us and they also take him home."

Improving care quality in response to complaints or concerns
● The provider had a policy and procedure in place to deal with complaints. They provided information on the action people could take if they were not satisfied with the service being provided.
● We looked in the complaints folder, there were complaints recorded. It was documented the complaint was investigated and discussed with the complainant. Written confirmation of the actions taken to address the matters detailed in the complaint took place in line with the providers complaints and concerns policy. We spoke to a complainant about their complaint, they told us things may start to improve now there is a new manager in place, however, they were reserving judgement.
● Other relatives told us they did not have cause to complain; however, they also told us they did not know how to complain if they needed to.
● There were no compliments recorded for the service.

End of life care and support
● At the time of the inspection no one was receiving end of life care.
● There was evidence end of life care documents had been started for people, however, they contained very basic information and did not evidence consultation with people or people who were important to them.

Requires Improvement

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Although there were governance systems and processes in place to help ensure the safe running of the service and they had identified a number of the concerns found on inspection, the provider and management team had not always acted on these concerns in a timely way. The concerns found at the inspection included but were not limited to, staffing, training, care records, risk management, consent and the mental capacity act, person centred care and medicines management.
- The provider failed to follow their own governance policy to ensure quality and safety. Audits were carried out, but these were not done in line with their policy because they did not always drive improvement.

The failure to operate effective systems to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act. 2008 (Regulated Activities) Regulations 2014.

- The regional manager who had been in post for 3 months at the time of the inspection was very responsive to concerns raised throughout the inspection and began to act immediately.
- The appointment of a new manager was positive. The manager started working on making improvements during his first week.
- The regional manager recognised improvements were required and was taking action to ensure systems and processes were in place to ensure they had good oversight of the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People were not always engaged and involved, and feedback was not always followed up on. For example, there was a survey sent to people's relatives. Relatives told us they did not always receive feedback or the outcome of the surveys.
- There was a lack of systems in place to evidence people were supported to express and review how they wanted their care to be provided. People were not given regular opportunity to discuss their individual care needs or wider issues in the home.
- Some staff told us they did not feel valued and listened to by the provider but had welcomed the regional manager and were looking forward to having a manager in the service.

The failure to seek and act on feedback from relevant persons and other persons on the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

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

● The culture of the service did not fully reflect the principles and values of our Right support, Right care, Right culture guidance. People did not live in a suitable or homely environment.

● There was a lack of evidence to demonstrate how people had been empowered to have as much control over their lives as possible.

● Systems did not evidence how people were supported to express and review how they wanted their care to be provided or how the home was run. People were not involved in developing their care plans. We have reported more about this in the responsive question of this report.

● We additionally noted that care plans did not include people's goals or longer-term aspirations.

● Staff told us they had not felt supported by the management team since the previous manager left some months ago. However, a new manager started to work at the service on the second day of our inspection. Staff have since told us they are feeling hopeful things will improve.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents and incidents occurred. We found this had not always been followed and concerns were not always reported to the local authority. We have reported on this in more detail in the safe section of this report.

● When incidents occurred, we saw evidence the provider had contacted relatives and responded in writing when required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The failure to ensure people were provided with person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to act in accordance with the MCA was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The failure to establish systems and processes and operate them effectively to prevent abuse of service users was 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	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to operate effective systems to assess, monitor and improve the service was 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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to ensure people were provided with safe care and treatment and risks were assessed, monitored, and mitigated was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to ensure safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issuing a Warning Notice for Regulation 12 requiring the provider to meet this regulation in a set timescale.