MNP Complete Care Limited

Sandgate Manor

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

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.

About the service
Sandgate Manor is a residential care home providing accommodation and personal care to 21 people at the time of the inspection. The service can support up to 25 people. Most people lived in one two story building. There were also three individual lodges on site each of which accommodated one person. The service provided support to people with a learning disability and autism and people with physical disabilities.

People's experience of using this service and what we found
Right Support
The service had not supported people to have the maximum possible choice, control and independence. People did not have control over their own lives. Staff did not respect people's rights. They had not made reasonable adjustments to enable people to do things for themselves. Staff did not focus on people's strengths and did not promote what they could do for themselves. People did not always have a fulfilling and meaningful everyday life.

Staff did not support people with their medicines in a way that promoted their independence. The support people needed with their medicines was not assessed. Some staff did not have training in emergency medicines, and this restricted how often, when and where some people could go out.

Most people were not supported by staff to pursue their interests or to achieve their aspirations and goals. People were not always enabled to access specialist health and social care support where appropriate. Staff did not always support people to lead their own health and make healthy choices.

Right Care
People did not always receive kind and compassionate care. Staff did not always protect and respect people's privacy and dignity. Some staff spoke to people in a disrespectful way at times.
Staff did not promote equality and diversity in their support for people. They had not assessed people's cultural needs to ensure they provided culturally appropriate care.

Staff had failed to recognise and act on concerns which needed to be investigated to ensure they were not the result of abuse. The service did not have enough appropriately skilled staff to meet people's needs.

What activities people wanted to take part in had not been discussed with people. People's care, treatment and support plans did not reflect their range of needs and promote their wellbeing and enjoyment of life.

Right culture
People were not supported by staff who understood best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have.

Staff had not placed people's wishes, needs and rights at the heart of everything they did. There was a lack of information about preferences to support people with these. People were not always involved in planning their care. People were not leading inclusive and empowered lives. However, there was a new manager in place who had started to address issues at the service.

Rating at last inspection
The last rating for this service was Good (published 31 July 2019).

Why we inspected
We received concerns in relation to the management of the service, staffing levels and people's support with risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led. We also identified concerns with how staff promoted people's independence, managed complaints and supported people with their health, so we widened the scope of the inspection to include all five key questions.

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

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

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

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 treating people with dignity and respect, staffing levels, providing safe care, person-centred care, the management of the service, safe staff recruitment, and reporting significant events to CQC at this inspection.

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

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.

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 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**

Sandgate Manor

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
Two Inspectors carried out the inspection.

Service and service type
Sandgate Manor 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.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was not a registered manager in post. However, an application to register a manager had been received.

Notice of inspection
This inspection was unannounced

What we did before inspection
We reviewed information we had received about the service since the last inspection. We received feedback from 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 this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and three relatives about their experience of the care provided. Some people did not communicate with us verbally. We observed how staff interreacted with people in areas such as the lounges and dining areas. 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 13 members of staff including the manager, the nominated individual, the deputy manager, the house manager, senior care staff and care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included all or parts of 16 people's care records and medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures 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

● People were not protected from the risk of abuse. Staff had training on how to identify and report abuse. However, they had not recognised potential abuse when incidents occurred. For example, one person had raised a complaint to staff. The complaint was an allegation that staff had said something inappropriate to the person. Staff had not considered if the matter was also verbal abuse. The concern was not reported to safeguarding at the local authority when it should have been. Another person had an unexplained graze. This was reported as an incident but there was no investigation in to how it occurred, and it was not reported to safeguarding. One person was recorded as having hit another person. There was no information on what action was taken to reduce re-occurrence. There was no record it was reported to safeguarding.

● People were not always kept safe from the risk of avoidable harm. Following a safeguarding incident relating to emotional-based behaviour, a new risk assessment for one person was put in place identifying triggers for the person. However, this was not shared with staff and not all staff were aware of sufficient details about the person's triggers and there was an increased risk of re-occurrence.

The provider had failed to ensure they were doing all that is reasonably practicable to mitigate risks to people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● When incidents had occurred, action was not always taken to reduce the risk. One person had a near miss choking on some meat. They had historical swallowing issues which had improved following medical intervention. Following the incident, no action had been taken to assess if the person's choking risks had increased or to reduce the risk of the person choking again. The person's care plan stated they needed their food cut up well, there was no investigation in to whether this had been done when the person choked. The person had capacity and could choose to take risks. However, it had not been documented if the person was aware of the risks and had made a decision to take this risk. There was no information for staff on what to do if the person was choking, however this was addressed during the inspection.

● Incident records were limited, and incidents were not well analysed. There was a lack of information on what the triggers for an incident might be. For example, one person was recorded as shouting and swearing. There was no information on what might have upset the person to enable staff to reduce the risk of them becoming upset again. There were no records of what action was taken following incidents to enable staff to assess what support strategies were effective to help the person feel calm.

● There was a lack of oversight of trends of incidents. There was no system in use to review incidents to identifying patterns. Identifying patterns can help staff understand why some incidents occur, for example whether incidents occurred more often at certain times of day. The manager had designed a system, but this

was not yet in use.

The provider had failed to ensure they were doing all that is reasonably practicable to mitigate risks to people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Risks to people were not always well managed. Some people had gastrostomy tubes in place but there was no information on the signs and symptoms of possible infection or blockage. A gastrostomy tube is a tube inserted through the tummy that enables people to take in fluid, nutrition or medication when they do not do so orally. Staff told us they would re-insert a tube if it fell out. Staff said they had been told to do this by the community nurse. However, there was no evidence they had been trained to insert these tubes nor that this had been agreed to by healthcare professionals. If staff re-inserted the tube incorrectly this could cause harm to the person. We raised this to the manager who told us they would arrange staff training with healthcare professionals.

● People's care records did not help them get the support they needed. Staff and agency staff did not always have access to guidance on how to support people as risk assessments contained limited and unclear information. For example, there were no risk assessments to support people with epilepsy whilst bathing. There were also no risk assessments where people had asthma. This increased the risk that staff might not support people correctly.

● Staff did not fully manage the safety of the living environment. During the inspection the fire alarm sounded. This triggered the doors to shut. Some doors locked automatically when they shut. Staff had not considered this could delay rescue staff reaching people in the event of a fire or other emergency. We raised this as a concern to the fire service.

● Other risks during fire alarms had not been considered. The fire alarm had sounded during lunch time. Staff assembled to the muster point whilst people continued to eat in the dining space. The door to the dining space shut. Staff had not considered how they would ensure people with choking risks were safe at this time with no staff present to support people.

The provider had failed to ensure they were doing all that is reasonably practicable to mitigate risks to people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were insufficient staff to provide support to people including providing one-to-one support. Some people were not receiving the one-to-one they were assessed as needing. Staff told us when they were short of staff people received less one-to-one support as a consequence. People also had limited opportunities to undertake activities or go out into the community as a result of there being insufficient staff. People were not happily engaged or stimulated.

● Some people told us they were bored, lonely and had nothing to do. We observed people being left for long periods of time without stimulation or interaction from staff. One person said, "They tell me to come downstairs but what is the point? When I come down to speak with staff all the other residents get the attention. No one talks to me."

● Relatives told us there were not enough staff. One relative said, "[My relative] has to wait to go to the toilet. They have to go when they need to go." During the inspection there were times when we had to go and find staff to provide support to people who were indicating they needed assistance.

The provider had failed to ensure there were sufficient numbers staff deployed. This was a breach of

regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager told us staffing levels had been worse in the months prior and that they had focused on improving this. Some prospective staff were in the process of being recruited and interviews were taking place.

● Staff were not always recruited safely. Services are required to seek a full employment history, together with a satisfactory written explanation of any gaps in employment for staff. We looked at three staff files none of which included a full employment history for staff.

The provider had failed to follow required recruitment processes. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Staff used appropriate personal protective equipment (PPE). However, PPE was disposed of in open-top bins and bins staff needed to use their hands to open. This increased the risk of transfer of infection. This was an area for improvement.
● The service used effective infection, prevention and control measures to keep people safe, and staff supported people to follow them. The service had good arrangements for keep premises clean and hygienic.

● The service prevented visitors from catching and spreading infections.
● The service admitting people safely to the service.
● The service tested for infection in people using the service and staff.
● The service promoted safety through the layout of the premises and staff's hygiene practices.
● The service made sure that infection outbreaks could be effectively prevented or managed. It had plans to alert other agencies to concerns affecting people's health and wellbeing.
● The service supported visits for people living in the home in line with current guidance.
● All relevant staff had completed food hygiene training and followed correct procedures for preparing and storing food.

Using medicines safely
● People's support needs for their medicines had not been assessed. Staff provided support to everyone who took medicines. No assessment had been undertaken to determined what people could do for themselves or with reduced levels of support.
● The manager told us people's medicines had not been regularly reviewed. However, they were making arrangements for this to be done.
● People's medicines were stored safely and kept secure.
● People received their medicines as prescribed. Medicines Medicine administration records (MARs) were complete and accurate.
● Where people had 'as and when' medicines, such as pain relief, there was guidance for staff in place. For example, how often these medicines could be administered during a 24-hour period.
● Staff received training to administer medicines and their competency was checked. People's medicines were reviewed as needed.

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.

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

- No one new had moved into the service for a number of years and the service had no vacancies. This was because the lodges could accommodate couples but were occupied by single people.
- People's needs had not always been well assessed. For example, people's needs and wishes relating to protected characteristics under the Equality Act 2010 had not been assessed. These needs include disability, gender, culture and religion. The design and layout of the service did not support people's individual needs. The kitchen and the laundry room were not accessible for people who used wheelchairs. This prevented people from undertaking things they could do for themselves. People who used wheelchairs could not enter the laundry room as the door was not wide enough. The kitchen worktops were too high to be used by people who were seated in wheelchairs. The manager told us they were planning to update the kitchen. However, they had not considered making the space more accessible to people.
- Some people living at the service had autism and staff had not considered if people had sensory needs. Many people with autism can find some things such as certain lighting, sounds, smells, textures and tastes overwhelming. Other people can benefit from sensory stimulation. These needs had not been assessed to determine if people needed support.

The provider had failed to have due regard to people's protected characteristics (as defined in section 149(7) of the Equality Act 2010). This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- People were not always supported by staff who had received relevant and good quality training in evidence-based practice. Some people at the service lived with epilepsy and were prescribed emergency medicines to be used in case of a seizure. Not all staff had undertaken training in administering these medicines. The manager and staff told us this restricted how often and when people could go out as they could only go out if trained staff were available.
- Not all staff had undertaken training in supporting people with epilepsy. There were no records of staff having completed training in gastronomy tube support. However, staff knew how to support people with these needs.
- The provider had not ensured staff had undertaken the training they needed to support people effectively. Some people at the service lived with learning disability and autism. Staff had not undertaken training in

this area to ensure they understood how to provide effective support to people. For example, staff were not providing person-centred active support to people. Active support is where staff provide only the support that is needed, rather than doing everything for people to promote independence.

The provider had failed to ensure there were sufficient numbers of suitably qualified and skilled staff deployed. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff supervision was not up to date to ensure staff had the support they needed and monitor practice. The manager had identified this and was addressing this issue. The manager had also assigned more training for staff which they had started to undertake.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

● Staff did not effectively encourage people to eat a healthy and varied diet to help them to stay at a healthy weight. For example, one person's care plan stated they were overweight and at risk of serious health issues. It also stated staff should encourage the person to eat healthier low sugar, low carbohydrate foods. We saw staff encourage the person to eat sugary food. The person's weight was not being monitored nor was there any use of weight indicators for people who used wheelchairs. What they ate was poorly recorded, when meals cooked by staff were recorded, they were high carb, high sugar meals such as cheesy pasta, pizza and jam tarts.

● People told us they were not supported to make healthy food choices. One person said, "I have a smoothie maker, I'd have to buy the fruit. I couldn't get it from the kitchen." We asked staff what snacks people could ask for, they listed a number of unhealthy foods and did not mention fruit until prompted by the inspector.

● There were no health action plans in place for people to set out what their health needs were and how they were being supported with these. One person told us they would like to see a health professional to review their mobility following an operation. There were no records of this, and no action had been taken.

● People were not always referred to health care professionals to support their wellbeing and manage risks. We identified two people who needed to be referred to the speech and language team for an assessment of their choking risks. We raised this with the manager who made the referrals during the inspection.

● People were not well supported to manage risks to their teeth and oral care. There were no oral care assessments in place to assess people's dental risks. Some people at the service had behaviours that increased their risk of poor dental health. There were no assessments about these risks. There were no records to show that some people with high risks had seen a dentist since before the pandemic. Staff had not undertaken training in oral care.

The provider had failed to assess the risks to the health of people and ensure they were doing all that is reasonably practicable mitigate risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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).

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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.

- We found the service was not working within the principles of the MCA. People were subject to unnecessary restrictions. For example, people were not allowed to access some areas of the service. There were no risk assessments in place to support these decisions.
- Capacity assessments and best interest decisions were in place for people where some decisions needed to be made.

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; there were significant shortfalls in promoting independence.

Respecting and promoting people's privacy, dignity and independence

- People were not supported to increase or maintain their independence. People had no plans in place to support them to maintain skills or develop new skills. There was a lack of information in people's care plans setting out what people could do for themselves.
- People were not supported to do things for themselves. For example, people were not supported to cook their own meals and make their own drinks and snacks. One person said, "I want to do my own cup of tea, but I can't do that here. We are not allowed in the kitchen now. The staff are allowed in the kitchen, but we are not allowed now because of Covid. But it's our home so I don't get that. I liked to put things in the dishwasher, but I'm not allowed here. The staff tell us we are not allowed in there." One staff told us, "As long as I have worked here people have not done their own cooking."
- Some staff were dismissive of people's abilities and had not considered how independence could be promoted using adaptations. For example, one person indicated they did not like the coffee staff made for them. They told us they'd like to make their own coffee. Staff then spoke over the person and told us the person was not able to do this because of their health conditions. However, there had been no consideration as to whether the person could do this safely with adaptations and/or support from staff.
- People were not supported to be more involved in managing their own medicines. There had been no review what people were able to do for themselves or with lower levels of support from staff.
- Some people told us their privacy was not always respected. One person said, "Staff walk into my bedroom, a couple of them and they don't knock or into the bathroom and don't knock. They act like it's their house but it's not, it's ours." Staff also told us people all received their medicines in a communal room and people were not offered the opportunity to take their medicines in private.
- People's dignity was not respected. Some staff also talked over people. One person was left for some time with food on their face before staff supported them to clean it off. They were supported to eat in the entrance hall by the door so would be on full view to anyone visiting the service. People told us their laundry was not well managed and their clothes were mixed up. Some people were not able to communicate verbally and would not be able to tell staff the clothes they were helping them put on were not theirs.

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 as staff's equal. We saw one person being made to say please before being provided with assistance to eat and then being called a "good girl" when they did. This was not a respectful way to speak to the person. Another person told us, "There's one or two [staff], it's their attitude, they don't say please or thank you. It doesn't take a minute to say please and thank you. We need them to

give us more respect."

● People's needs in relation to equality and diversity were not being promoted. One person wanted to spend more time with a loved one. There were barriers to this happening, some of which were outside of the service's control. However, staff had not advocated as much as they could have for the person. Alternative solutions had not been fully explored. The person was unhappy and told us their human rights were not being respected.

● Some people did not feel listened to or valued by staff.

● People did not have a clear voice in their own support. Throughout the day people told us about things they wanted to do for themselves. However, this had not been taken on board and people's views on their independence had not been listened to.

The provider had failed to ensure people were treated with dignity and respect and their privacy maintained. The provider had failed to ensure people were supported with their independence and have due regard to their protected characteristics (as defined in section 149(7) of the Equality Act 2010). This was a breach of regulation 10 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

- People told us they were not involved in developing their own care plans. The manager had recently undertaken a survey for people. They had asked people 'Do you have a personal involvement in your care plan'. Eighty percent of people had indicated they did not to some level; 40% had said not really and 40% had said not at all.
- Care was not planned in a way which promoted people's individualism or responded to their individual needs. For example, there were toilet rounds where people were taken to the toilet one after the other, rather than when they needed this support. People told us they had 'shower days' which were set days they could take a shower.
- People's support focused on tasks rather than people's quality of life outcomes. Most people had not been supported to set goals or aspirations. There was no information on what people wanted to achieve or plans to support people to achieve these goals. The nominated individual told us they had started to have some discussions with two people. However, there was no plan for other people.

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's preferences about the activities they wanted to engage in had not been discussed with them. The manager told us they planned to address this by introducing a keyworker system and that the keyworker would spend time with people discussing what activities people wanted to explore.
- The manager told us prior to them starting in post people were not participating in any activities at all. People told us this had started to improve. For example, during the inspection people participated in a picnic and bowling. However, there was still significant improvement needed and people were not living happy and fulfilled lives.

The provider had failed to ensure people were supported in line with their preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were supported to see their relatives and speak to them when they wanted to do so.

Improving care quality in response to complaints or concerns

- Some people told us they were not sure how to raise a complaint.
- Complaints were not always recorded to enable the manager to monitor if it they had been fully resolved and to help spot trends in complaints which needed to be addressed. There was one complaint recorded.

However, people and their relatives told us they had raised other complaints. For example, there had been a complaint about a member of staff. The nominated individual had undertaken some action but there was no record of the complaint.

● Some complaints had not been addressed. For example, people and their relatives told us they had complained about items of clothes going missing or being worn by other people. There was no record of these complaints and people told us the concerns had not been addressed.

The provider had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

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

● People had communication plans and there was some information on how some people communicated. However, this was limited in some areas where people used accessible technology to communicate. However, staff had good awareness and understanding of individuals' communication needs, they knew how to facilitate communication and when people were trying to tell them something.

● Some easy read information was available to people. However, people's care plans had not been made accessible to them. The manager told us they planned to address this by introducing a keyworker system and that the keyworker would support people to understand information. This is an area for improvement.

End of life care and support

● At the time of the inspection the service was not supporting people at the end of their life.

● Staff had not completed training in end of life care to enable them to be prepared to support people if they did need this support in the future. This is an area for improvement.

● People had end of life care plans in place. For some people these did include details. However, other people's end of life plans included limited information and needed to be reviewed to ensure people had had an opportunity to express their wishes. This is an area for improvement.

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

- There was a poor culture at the service which disempowered people. This created a risk of people being de-skilled and did not promote people's confidence to do things themselves. Staff didn't treat people with dignity and respect. People were not empowered to make choices and decisions.
- The manager lacked oversight of staff performance. There was a new manager in place who had commenced in the role in February. They were managing this service whilst remaining the registered manager for another service. This reduced the time they were able to spend on site to oversee practice and make improvements. The manager was based in an office in the grounds of the service. There was also a new nominated individual who was providing support. One person said, "They [staff] can be rude. Raise their voice. The staff don't do it when the managers come over." Some people were positive about the new management arrangements. However, one person told us they did not know who the manager was and didn't see them. Another person said, "The new manager is hands off."
- The provider had not kept up to date with best practice and people's care and support were not being delivered in line with right support, right care, right culture.
- There was a deputy manager and house manager in place. However, communication between the management team needed to be improved to enable the manager to drive forward improvements quicker and more effectively.

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

- A survey of people's views was completed in March 2022. Feedback from people was mixed. Overall, 80% of people said they were happy with the service. However, 20% of people said they would not recommend the service and rated their care inadequate. At the time of the inspection the manager told us the results were still being analysed.
- Some people told us they did not feel listened to. For example, one person told us they had been complaining about their bed for a long time, it was uncomfortable to sleep on and it had not yet been changed. The manager was not aware of this complaint. This was addressed during the inspection.
- Staff also participated in a survey in March. Feedback was again mixed. Some staff were positive about the service, for example, 83% would recommend it as a place to work. However, some staff identified areas where the service needed to improve. Twenty four percent of staff rated the kindness and respectfulness of colleagues needed to be improved. At the time of the inspection the manager told us the results were still being analysed.

● Communication with staff needed to be improved. The last recorded staff meeting was dated 11 April 2022. Other than the management team, five staff had attended. The meeting prior to that was 01 February 2022 where 4 care staff attended. Notes from these meetings were brief and there was no evidence the culture of the service was discussed. This was a missed opportunity to seek to make improvements to people's experience of the service.

The provider had failed to assess, monitor and improve the quality and safety of the service. The provider had failed to act on feedback from people. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager told us they were planning to start a residents' forum to enable people to have the opportunity to discuss their views. However, this had not yet taken place.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others
● Governance processes were not effective and did not hold staff to account. They did not ensure people were kept safe, people's rights were protected, and good quality care and support were provided. Prior to the inspection the manager had developed an action plan. The action plan stated all incidents had been reviewed. We identified incidents and safeguarding concerns where no action had been taken.
● The action plan stated staff files had been reviewed. However, we found there were issues with staff files missing work histories. This was also the case for staff training. Infection prevention control audits had not identified staff were disposing of PPE incorrectly.
● The manager had not fully prioritised improving people's safety and their experience of the service when planning quality improvement. The action plan showed that a number of administrative and process tasks had been prioritised, but that people's care plans, risk assessments and health needs had not been reviewed.
● People's care plans were not up to date. There was a paper system running alongside an electronic system. This led to care plans not being clear as information was in a number of different places. The support provided to people was not well documented to enable the manager to oversee staff practice. For example, there was a lack of records about when people were supported to change their continence pads.
● Where people were deprived of their liberty the legal authority to do so had expired and new applications had not been submitted as required.
● Some records about people's care were not kept securely. During the inspection we saw one office was left open and unattended. The door to this office lead to the car park and delivery people and other visitors came and went. The cabinets were not locked, and they contained some confidential information.
● Staff worked in partnership with health and social care professionals such as doctors and where people needed support with gastronomy tubes. However, staff had not referred one person to the speech and language team following an incident of choking. We raised this as the inspection and the referral was sent.

The provider had failed to assess, monitor and improve the quality and safety of the service. The provider had failed to maintain securely accurate, complete and contemporaneous records. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We identified a number of concerns that should have been reported to the local authority safeguarding team. For example, where people had bruising or incidents between people. When a safeguarding incident occurs, a notification should have been sent to CQC. CQC was not notified about these events. Notifications support CQC's monitoring of services and enable us to identify and respond to risk. Following the inspection, we raised these concerns with the local authority.

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 manager was aware of their responsibilities under duty of candour. A duty of candour incident is where an unintended or unexpected incident occurs that result in the death of a service user, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident. We did not identify any duty of candour events. However, incident records at the service were poor and actions were not always taken as a result of incidents.

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 provider had failed to ensure people were supported in line with their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to follow required recruitment processes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitably qualified and skilled staff deployed.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure they people were treated with dignity and respect and their privacy maintained. The provider had failed to ensure people were supported with their independence and have due regard to their protected characteristics (as defined in section 149(7) of the Equality Act 2010).

The enforcement action we took:

We took enforcement action against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure they were doing all that is reasonably practicable to mitigate risks to people. The provider had failed to assess the risks to the health of people.

The enforcement action we took:

We took enforcement action against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints.

The enforcement action we took:

We took enforcement action against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

The provider had failed to assess, monitor and improve the quality and safety of the service. The provider had failed to maintain securely accurate, complete and contemporaneous records. The provider had failed to act on feedback from people.

The enforcement action we took:

We took enforcement action against the provider