Leonard Cheshire Disability

# Agate House - Care Home with Nursing Physical Disabilities

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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
Agate House- Care Home with Nursing Physical Disabilities is a residential care home providing personal and nursing care to 32 people. Most people using the service were living with a physical disability and some people were autistic or living with a learning disability. The service can support up to 36 people.

Agate House- Care Home with Nursing Physical Disabilities provides all accommodation, communal areas and therapy support on one level. The building is split into four separate wings, each of which has adapted facilities. People share communal areas such as kitchens, lounges and bathrooms and have their own bedrooms.

People's experience of using this service and what we found
Right Support
● People were not supported to pursue their interests or achieve their aspirations and goals.
● People were not being supported to try new things or to follow social interests and past times.
● Reasonable adjustments were not always made so that people could be fully involved in discussions about their support, including support to travel where they needed to go. Staff did not communicate with people in their identified and preferred methods.
● Staff did not focus on people's strengths or promote their independence, so people had a fulfilling and meaningful everyday life.
● People were not supported to make meaningful choices about their care and support.
● People did not benefit from an interactive or stimulating home environment and often felt isolated or bored.
● The service gave people care and support in a clean environment which met their physical needs and people were able to personalise their bedrooms.
● The service worked with people to plan for when they experienced periods of distress so that their freedoms were restricted only if there was no alternative.
● Staff supported people safely with their medicines.

Right Care
● Staff were not encouraging people to try new things which may have enhanced their wellbeing and enjoyment of life.
● People who had individual ways of communicating such as using symbols or body language could not

always interact comfortably with staff as they did not have all the skills necessary to understand them.
● Staff did not have the training or knowledge to support people effectively. The registered manager was not checking staff competency to perform their job roles consistently.
● People's support plans did not fully reflect their range of needs and promote their wellbeing and enjoyment of life.
● Staff did not support people to assess any risks they might face in a safe way and did not support people to take positive risks.
● Staff did not promote people's equality and diversity and did not know them well as individuals.
● People were not receiving kind and compassionate care which fully promoted their privacy and dignity.
● The service did not have appropriately trained and skill staff to keep people safe.
● Some staff members knew people well and communicated with them in a kind and compassionate manner.

Right culture
● The management and staff team did not understand the key principles of guidance such as Right Support, Right Care, Right Culture. Audits completed at the service by management had not picked up on areas that could have been improved to help support a more positive culture.
● People and those important to them, were not always involved in planning their support. Staff did not evaluate the quality of support provided to people, involving the person, their families and other professionals as appropriate.
● Staff turnover was very high meaning people did not receive consistent support from a staff team who knew them well.
● People did not receive good quality care and support and were not supported to lead inclusive and empowered lives due to the negative culture at the service.
● Staff were not responsive to people's needs and did not work well together to achieve good outcomes for people. People and relatives told us they were unhappy with the support they were receiving.
● There was a risk of a closed culture at the service and staff and the management team had failed to make or sustain improvements at the service.
● Some staff worked hard to achieve good quality care and good outcomes for people.

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

Rating at last inspection
The last rating for this service was inadequate (report published 15 December 2021) and there were breaches of regulation. At this inspection we found the provider remained in breach of regulations. The overall rating for this service has remained inadequate based on the findings from this inspection. This service has been rated inadequate for two consecutive inspections.

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture. This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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

The overall rating for this service remains inadequate. We have found evidence that the provider needs to

make improvements. Please see all the sections of this full report.

You can see what action we have asked the provider to take at the end of this full 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, safe staffing levels, staff training, people being treated with dignity and respect, person centred care and good governance at this inspection. Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service was not safe.<br>Details are in our safe findings below. | **Inadequate** |
| **Is the service effective?**<br>The service was not effective.<br>Details are in our effective findings below. | **Inadequate** |
| **Is the service caring?**<br>The service was not caring.<br>Details are in our caring findings below. | **Inadequate** |
| **Is the service responsive?**<br>The service was not responsive.<br>Details are in our responsive findings below. | **Inadequate** |
| **Is the service well-led?**<br>The service was not well-led.<br>Details are in our well-led findings below. | **Inadequate** |

# Agate House - Care Home with Nursing Physical Disabilities

**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.

Inspection team
Three inspectors, a member of the CQC medicines team and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Agate House- Care Home with Nursing Physical Disabilities is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. Agate House- Care Home with Nursing Physical Disabilities is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This 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 a registered manager in post.

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 sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke and communicated with 16 people who used the service and nine relatives/ friends of people about their experience of the care provided. People who used the service who were unable to talk with us used different ways of communicating such as using their body language. We spent lots of time observing how staff interacted with people using the service.

We spoke with 23 members of staff including support workers, activity support workers, domestic care staff, team leaders, cooks, the maintenance team, the deputy manager, the registered manager, the regional manager, members of the quality management team and the nominated individual.

We reviewed a range of records. This included five people's care records and multiple medication records and monitoring charts. 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with a professional who regularly visits the service.

Inadequate

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At our last inspection robust systems were not in place to calculate and review staffing requirements. There were insufficient staff to meet people's needs. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18(1).

● There were not enough staff to support people safely. During our visits to the service there was a noticeable lack of staff presence and people were left for extended periods of time without support both in communal areas and their bedrooms. We observed several times where staff would stand together and talk away from people. Some people were left for a number of hours without any interaction from staff members.
● People were at risk of harm as they were being supported by staff who may not know how to support them safely. On several occasions during our visits to the service agency staff, who were unfamiliar with people, were the only staff available to support them. On our second visit to the service the agency nurse in charge of the shift told us they had only worked at the service one shift before. The provider later showed us evidence this staff member had worked at the service seven times before.
● Staff were not confident working with agency staff and felt they had to check and make sure people had been supported safely. One staff member told us, ''Weekends are hardest. Last weekend it was just me and agency staff and two of the agency staff were brand new, so I had to do everything. I had no time for a break.''
● People told us they waited for long periods of time for staff to help them. We observed people waiting to be served meals and waiting for personal care until late in the day, when this was not their choice. One person said, ''[Personal care] is functional and I do not relax. Staff will often ask if I can go without a bath as there are not enough staff to support me.''
● Relatives also shared their concerns around staffing levels. One relative told us, ''The service is definitely not safely staffed. It takes a long time for [family member's] most basic of care needs to be seen to.'' Another relative said, ''[Family member] has given up waiting for staff to come and help them use the toilet. They [use other method now] rather than being supported to go to the toilet. They could have been helped to use the bathroom.''
● Feedback about the support people had from agency staff was negative. One person told us, ''[Agency staff] do not understand me. They sometimes do things completely differently to how I ask them to do it. This might seem a small thing to them, but it makes me very upset.''

● The registered manager used a dependency tool to decide safe staffing levels. However, this was not reviewed in practice to ensure staffing levels were safe. The registered manager told us agency staff did not work without the supervision of a permanent staff member. However, our observations and rotas showed this was not the case.

We found no evidence people had been harmed. However, there were not enough staff to support people in a timely manner or in line with their preferences. This put people at risk of potential harm. This is a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team spoke to us about the challenges they were having regarding recruiting new staff members. They had plans in place to try and drive recruitment forward.
● The registered manager also told us they would continue to review staffing levels and discuss these with partners.
● The provider completed employment checks on staff members in line with legal requirements to help ensure they were suitable for their job roles.

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

At our last inspection systems were either not in place or robust enough to mitigate risks, where possible, to people's safety. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

● People's risk assessments and records for pressure area care did not make it clear when they should be supported by staff. Risk assessments did not give staff clear guidance as to how often people should be supported to move to reduce the risk of pressure sores developing. Records showed people were not supported to be moved regularly and were supported inconsistently throughout the day. One person told us, ''I have to press the buzzer, so staff come and [support me with pressure area care]. They would not come otherwise.''
● People who required their food and fluid to be monitored, were not being supported to do this consistently. Records were not completed on occasions and risk assessments did not make it clear how much food or fluid people needed to maintain their health and wellbeing. Where people did not meet identified targets, actions were always recorded as 'encourage more food and fluid'. No consideration had been given to taking other actions.
● People did not always receive food and fluids of the right consistency. One relative said, ''I visited [family member] and staff had made their drink far too thick. They were trying to drink some liquid out of it but could not. This is not the only time I have had to point this out to staff.''
● Staffing levels at the service put people at risk of potential harm. When we visited the service the second time, we were let into the building by a person using the service as no staff were available. Staff did not ask us who we were or ask for any identification as we walked through the service to the nursing station. This put people at risk of having unwanted visitors enter their home.
● Risk assessments and support plans contained conflicting information about people's support needs. This meant key information about people may not be known to staff supporting them. For example, people's allergies had not been recorded in support plans or passports which people would take with them for hospital or health appointments. Side effects of medicines people were taking were also not always recorded in their support plans. It was not clear on risk assessments why people needed to be supported

with equipment such as bed rails.
● During our first site visit the door to the boiler room was unlocked and left open. This was supposed to be locked and posed a health and safety risk to some people using the service.
● Staff had a poor understanding of how to support people in the event of an emergency. There had not been any fire drills conducted at night-time at the service for an extended period of time. Risk assessments were not clear regarding how to support people, were there to be a fire at night-time.
● People were at risk of harm from using incorrect equipment. Some people using the service used equipment to support them to move. It was unclear how often some of this equipment was being serviced and, in some cases, equipment meant for one person was being shared between several people.
● The registered manager reviewed incidents and accidents for any potential lessons that could be learned. However, in most cases there were no actions taken as a result of incidents happening and it was unclear how lessons were being shared with the staff team.

We found no evidence people had been harmed. However, systems were not robust enough to mitigate risks, where possible to people's safety. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team responded to our feedback and said they would review risk assessments and monitoring forms to ensure they were fit for purpose.
● Some risk assessments gave a good level of detail. One relative told us, ''I have no reason to believe [family member] is unsafe. Everything seems to be in order.''
● Staff completed health and safety checks of the environment to help ensure people stayed safe.

Preventing and controlling infection
● We were not fully assured that the provider was preventing visitors from catching and spreading infections.
● We were not fully assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were not asked to provide evidence of a negative lateral flow test during our visits to the service, in line with the provider's policy. This meant the provider's infection prevention control methods relating to COVID-19 were not being followed.
● We were assured that the provider was meeting shielding and social distancing rules.
● 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 accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider's infection prevention and control policy was up to date.
● People were supported to have visitors to the service in line with current government guidelines.
● The service looked and smelled clean. However, we received mixed feedback from people and relatives about this always being the case. One person told us, ''There have been issues with cleanliness here especially in the kitchens. We have even tried to take pictures to show the manager.''. A relative said, ''I have concerns about cleanliness recently. I visited my family member and their room looked very unkempt.''
● Other people were more positive about the cleanliness of the service. One person said, ''It is very clean here and [staff] are always nipping in and giving my room a quick tidy.''
● Domestic staff confirmed they had the equipment and the time to complete cleaning duties effectively.

Using medicines safely

● For the most part, people were supported safely with their medicines. People received medicines on time and were supported in line with their preferences. One person told us, ''No problems with [medicines]. I always get them when I need them and do not have to worry about running out of tablets.''

● Some people were prescribed 'as and when required' medicines. Protocols in place for these were not always detailed to let staff know when these medicines should be administered.

● Medication audits were not always effective in identifying and correcting medication errors. We discuss this more in the 'well-led' section of the report.

Systems and processes to safeguard people from the risk of abuse

● Systems in place to protect people from abuse were not always effective. For example, it was unclear what actions were taken when people had unexplained bruises. Records were not detailed to show how people had been safeguarded in these cases.

● Staff had been trained in safeguarding, however some staff did not know who to report concerns to outside of the service, such as the local authority safeguarding team or CQC.

● Despite our findings people and relatives told us they felt safe. One person said, ''I am safe here. I have everything I need in my room.'' A relative told us, ''[Family member] is safe and in good hands. [Staff] know their needs well and the nurses are responsive to any changes.''

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 requires improvement. At this inspection this key question has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection robust systems were not in place to ensure staff had the support, training, skills and experience to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18(2).

● People and relatives raised concerns about the training and knowledge of some staff. One person said, ''I am worried about some of the staff. I do not think they have training in supporting me with [medical condition] and this is a massive red flag for me.'' Another person told us, ''I am concerned about the moving and handling training of some staff. I do not feel safe when they support me with [piece of equipment] and I do not think anyone is checking they are OK to do it.''
● Relatives comments included, ''Training is a bit of a joke between me and [family member] particularly with the new staff. They don't seem to know what they are doing- staff cannot even talk to [family member] to make them laugh liked they used to'' and, ''Some staff do not have the training and tend to just do the bare basics of care.''
● Some staff had not completed training in supporting people living with different support needs such as learning disabilities, diabetes or epilepsy. There was no evidence that agency staff had training in these areas. The registered manager was unable to show us evidence of this. Staff had a poor understanding of some key aspects of their training such as supporting people living with a learning disability or people living with specific health conditions.
● We were not assured staff were receiving support to ensure they had the skills and experience to support people effectively. There was no evidence of competency checks or supervisions being completed with agency staff who were working a lot of shifts at the service.
● Inductions for some staff were completed quickly with all areas relevant to their job roles covered in one day. We could not be assured this was adequate time for staff to be fully inducted into their job role. There were no records of competency checks being completed to ensure that these inductions had been effective.

We found no evidence people had been harmed. However, systems were not in place to ensure that staff had the support, training, skills and experience to support people safely. This was a breach of regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people felt staff had appropriate training and knowledge. One person said, ''Some [staff] are really excellent and know exactly what they are doing.'' Some staff also showed good knowledge of the training they had completed.

Supporting people to eat and drink enough to maintain a balanced diet
● People did not have a positive mealtime experience. People were left waiting for their meal for extended periods of time. Some people were served their meals but were not given the equipment or support they needed to eat their meals in a timely manner.
● Some people were waiting up to 35 minutes to be supported, by which time their meals would have been cold. A staff member told us, ''[Person] will have to wait as we only have two staff around to support people at the moment.''
● People who needed their food and fluid intake monitored were not supported consistently with this, as discussed in the 'safe' section of this report.
● Whilst food, looked and smelled appetising, we received negative feedback from people about the food. People's comments included, ''Food hasn't changed since you were last here. Take it or leave it- I have to eat it.'' Another person said, ''I find myself just asking for the same food again and again as I do not like the main meals that are on offer.''
● Other people were more positive about the food. One person said, ''The food is good here. I can have my favourite whenever I want it.''

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Relatives raised concerns about staff not working with other professionals to support people effectively. One relative said, ''[Family member] used to be able to [complete task independently] but has now lost the ability. I pointed this out to staff, and they made a referral to [health professional] but it was far too late by then.'' Another relative told us, ''[Family member's] health was getting worse and [staff] had no plan to help them- they just logged it down. I took [family member] to the GP myself in the end.''
● One person's friend explained they came in to make sure the person completed their physiotherapy exercise as directed by a health professional. This was because they were not assured staff would do this.
● People had 'hospital passports' in place which gave information to health professionals who may have to support them. However, these were missing key information such as people's allergies and were not updated at the same time as people's support plans and risk assessments. This meant professionals may not have the knowledge to support people effectively.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider did not have a good understanding of current best practice guidance around supporting autistic people and people living with a learning disability such as Right Support, Right Care, Right Culture. This was not a focus of people's assessments and there was a poor understanding of this amongst the staff team.
● People's needs were assessed when they started living at the service and reassessed if their needs changed.

Adapting service, design, decoration to meet people's needs
● Some areas of the service had recently been redecorated. However, some people did not like this. One person said, ''Things have not changed here despite the childish decorations they have put up.''
● The service was large and spacious to ensure that people who used wheelchairs could move around safely.
● People were supported to personalise their bedrooms.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People were supported in line with the MCA. Capacity assessments, best interest decisions and DoLS were in place for people as required.
- Some staff had a poor understanding of the MCA and the impact this had on their job roles. The management team assured us they would be discussing this with the staff team.

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 requires improvement. At this inspection this key question has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity;

At our last inspection robust systems and observational checks were not in place to protect the rights of people. This placed people at risk of not receiving respectful and dignified care. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach or Regulation 10.

● People were not supported with kindness and compassion. Staff talked to each other where people could hear them clearly, sometimes about people's personal information. Staff congregated and spoke to each other, rather than involving people in conversations or having one to one discussion with people.
● Staff spoke with each other in languages people could not understand. We observed this and people also told us this happened. One person said, ''[Staff] do not understand me. They talk to each other and I do not know what they are saying about me. It makes me worry.'' A relative told us, ''We have raised the issue of staff speaking to each other in [language] before but nothing seems to get done.''
● People told us some staff would not listen to them and this made them frustrated. Staff would then refuse to talk to them if they became frustrated. One person said, ''I can sound loud and cross when I get frustrated, but this is just how I feel if people do not understand me. Rather than try and help me, staff just leave saying they don't want me to be upset. This makes me feel very upset.'' Another person said, ''I am worried about the people living here who cannot speak up, so I try and speak up for them. I am usually told this is not my place and that I should not comment.''
● We heard staff members refer to people as their room number, rather than by their name. Staff also pointed to people and loudly explained to other staff the support the person needed. This did not promote people's dignity or respect.
● Staff entered people's bedrooms without knocking or introducing themselves. They would then start completing tasks without speaking to people. One relative told us, ''[Staff] often walk in to [family member's] room and this startles them.'' This did not respect people's privacy.
● Staff moved people in wheelchairs without telling them they were going to do so. Staff also placed aprons around people's necks without letting them know this was happening. This did not uphold people's dignity.
● People were at risk of social isolation as staff were not communicating with them. One person said, ''[Staff] used to come and spend time talking to me but not anymore. 'We don't have time' is the usual

excuse.'' Another person said, ''The staff very rarely speak to me anymore. I just watch TV unless my relative visits me.''

● People's equality and diversity was not supported. One staff member told us a person wanted food prepared according to their culture. The staff member asked the kitchen staff to prepare this for the person and was told ''We do not do [cultural food] here.'' The staff member stated the food was simple to make and they were disappointed with this response.

● One person had a cultural need identified in their support plan, involving visiting a building. This had not been supported by the staff team, even when restrictions around COVID-19 allowed this.

Respecting and promoting people's privacy, dignity and independence

● Staff did not promote people's independence. For example, people were not given cutlery to use whilst eating which would have enabled them to eat themselves.

● People and relatives gave us examples of independence not being promoted. One relative explained, ''[Family member] is able to do some things themselves but [staff] often do it for them and this frustrates [family member]. I think they do it to save time.'' Another relative told us, ''[Family member] has lost a lot of their skills recently. They have lost the ability to speak and move about themselves. If you do not use it, you lose it.''

● The management team were not checking that staff gave kind and compassionate care to people. They were not checking staff competency in this area. Following the last inspection staff had completed a 'dignity' workshop however this had not been effective.

● People's support plans did not give guidance to staff about how to support people to be independent.

People were not receiving kind and compassionate care and were not being supported to be as independent as possible. This placed people at risk of not receiving respectful and dignified care. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People praised some members of the staff team and their kind nature. Comments included, ''Some of the long-standing staff are excellent. It is just a shame I do not see them as much anymore because they are so busy'' and ''It is nice here. The people and staff make it that way.'' A relative said, ''I think staff do care about [family member] and look out for them.''

● Some staff members spoke about people in a kind and compassionate way and knew them as individuals.

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

● People were supported to make some day to day choices such as what to eat or drink. However, people did not always have a choice about when to have personal care and mealtimes were at set times with no flexibility around this. One person told us, ''The regimented mealtimes is just too much.''

● People and relatives had not been supported to discuss and make decisions about their care and support. This was not recorded in people's care records. One person said, ''I have never seen my care plan and it has never been discussed with me.'' A relative said, ''Staff do not involve [family member] in their care. They cannot have personal care whenever they want, and their likes and dislikes are not recorded anywhere. There is a care plan, but it has not been shared and I have not seen it.''

● We observed some staff asking people if they were happy with their support in the moment and making changes if the person wanted this.

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 requires improvement. At this inspection this key question has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

At our last inspection people were not always being supported in a person-centred manner. People were not engaged throughout the day, and people's individual likes; dislikes and preferences had not been sought nor considered in all instances. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9.

● People were not receiving personalised care. There was a lack of focus on people's preferences and choices and the importance of these when supporting people to have their needs met.
● Staffing levels and staff competency meant people could not have their preferences met regarding when they were supported with personal care or ate their meals. One person explained they would often not have personal care as their preferred gender of staff was not available to support them.
● People and relatives told us staff did not know them/ their family member as individuals. One person said, ''I just stay in my room all day. All the staff have changed, and I do not know who anyone is anymore. Staff talk to each other and I cannot understand them, and this makes me really upset.'' Another person told us, ''Staff do not interact with me or other people living here. They leave people without any support for ages as well. Definitely not what it used to be.''
● Relatives comments included, ''Some permanent staff do care, but most staff have a bit of an attitude and are quite uncaring. They only want to do the basics'' and, ''The level of care is not the best and has been quite poor for a little while. We are promised lots of things, but nothing changes, and nothing happens.''
● There was limited information about people's preferences, likes and dislikes in their support plans. Staff did not have a good knowledge of people's individuals' preferences and ways of being supported.
● Staff were not supporting people to leave the service, try new things or engage in their interests. Some people had decided to pay for their own support above what the service was offering to ensure they could leave the service. Relatives and friends told us they made sure they supported people to leave the service as they were worried people were not being supported by staff.
● People had been supported to set 'goals' in their support plans. These were generic and were not specific to the person. There was no evidence that these 'goals' had been discussed with people or if they were something that could be achieved easily.

● Some staff were employed to help ensure that people had social stimulation and were supported to follow their interests. However, these staff were asked to help other staff at key points of the day such as mornings and mealtimes. These staff explained they were given time to support people on an individual basis, but this did not happen as there was not enough time. This took away the opportunity for people to be engaged in their interests and pastimes.
● Social events were poorly attended and often did not make sense to people using the service. For example, a 'pilates' class which was to last one hour only lasted 12 minutes. Quizzes took place however, people who were unable to communicate verbally were not supported to take part in this.
● One person said, ''[Staff] organised basketball but I am unable to play so that is no good for me. I stay in my room instead.'' Another person told us, ''Activities are one size fits all here. I won't take part in them as they are too childish, and I do not want to draw fluffy clouds. I am a grown man.'' Another person stated they liked the idea of 'wheelchair dancing' however the activity itself was not suitable for them and they were unable to take part.
● Relatives were also concerned about the lack of stimulation available for people. Their comments included, ''[Staff] just leave [family member] sitting watching TV and there is more to life than this'' and, ''The only thing [family member] does for interests is stay at the service. They do not go out anymore.''
● There were a lack of social stimulation and people were left sitting for long periods of time with nothing to occupy them. Some people were left for nearly two hours alone in their bedrooms or listening to the radio in a communal area by themselves. One person said, ''There used to be lots of fun and laughter here, but I am lucky if [staff] even say good morning now.''
● Records confirmed people were not being supported to follow past times and interests or being supported to leave the service to access new opportunities.
● Staff were unable to explain people's individual likes and dislikes to us and were unclear how to support people in line with their choices and preferences.

People were not supported in a person-centred manner. People were not engaged throughout the day, and people's individual likes; dislikes and preferences had not been sought nor considered. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team told us they had plans in place to improve social interests and activities outside of the service for people. However, we could not be assured these would be effective as there had been no improvements in this area since our last inspection.
● Some people were more positive about the social pastimes on offer. One person said, ''I like the activities and staff always help me join in.''

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.
● There was limited evidence of the AIS being used consistently and effectively at the service. Staff spoke to people using verbal language regardless of identified communication needs. We did not see staff using other methods such as signing or pictures to help people communicate. One relative said, ''[Family member] had cards and pictures they used to us, but staff do not do this anymore. I am not sure they even know where they are.''
● One person told us they were frustrated as staff did not seem to understand them. A friend visiting this

person said, ''It is a shame as [person] might sound angry when they are frustrated but this is not their fault if staff do not understand them properly.''

● People's support plans were not available in an accessible format which may have helped them understand their content.

● Staff told us they had not had training in different communication methods and would find this useful for their job roles.

End of life care and support

● People had been supported to put plans in place for the end of their life. These were not always very detailed and would have benefitted from having more personalised information about what was important to people at this time.

● Staff did not have training in end of life care but knew they could contact other organisations for support if this was needed.

Improving care quality in response to complaints or concerns

● There was a complaints policy in place for people and relatives to use. Complaints were responded to in a timely manner. One person said, ''If anything was wrong, I would let staff know and they would tell the manager.''

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 inadequate. At this inspection this key question has remained the same. 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.

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

At our last inspection the provider had failed to consistently assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to improve the quality of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

● There had been a lack of improvement at the service since our last inspection and the same issues were still prevalent. The management team had put a large service improvement plan in place with over 100 actions on it. However, this had not been effective in driving or sustaining improvements.
● Audits completed by the management team did not identify actions needed to improve the service as identified at this inspection. This included staffing levels not being adequate, staff not having training and knowledge to perform their job roles, people not receiving kind and compassionate care, people not being supported in line with their preferences or to leave the service and pursue their interests.
● Numerous checks were in place to monitor the quality of the service. However, some of these were repetitive and staff did not complete these consistently. On some occasions the same piece of information was recorded three times on separate recording forms. These checks were not being reviewed to ensure they were effective in driving improvements at the service. Staff expressed frustration at the amount of records they were being asked to complete and how often these were changed by the management team.
● The management team and nominated individual did not put the principles of Right Support, Right Care, Right Culture in to practice at the service. This was not a focus of the staff team and led to people missing opportunities to live a full and active life.
● There was a poor culture at the service. There had been a high staff turnover and people were unhappy being supported by agency staff who they felt did not understand them. One person said, ''I do not think things are going to get better or go back to how they were here. It is too late for that and too many good staff have left.''
● Staff did not have the time, or when they did have time, did not spend it interacting and communicating with people. They did not focus on people's quality of life or support them to learn new skills and be an

active part of their community. One person told us, ''I have lived here for [extended period of time] and have never seen it this bad. It is the first time I have wanted to move.''

● Staff did not work well with agency staff and explained their frustrations when they had to repeat tasks that agency staff were to complete. We observed a clear divide between staff and agency staff during our visits to the service. Agency staff spent a lot of time conversing together rather than spending time with people using the service. One person said, ''It is no wonder staff are leaving. There is too much pressure on them and if agency staff make a mistake then they are the ones who get the blame.''

● Relatives also shared concerns about the culture of the service. Comments included, ''[Staff] do not acknowledge what people need and do the bare minimum and this is very obvious. No improvements have happened, and staff are not approachable'' and, ''There are barely any staff who knew my family member well there now. Things have fallen apart with all the changes.''

● Throughout our inspection there was a visible lack of enthusiasm and willingness to support people and spend quality time with them. Support was task based and people were at risk of social isolation. One person told us, ''I feel very lonely now. Staff used to come and talk to me but not anymore. I tend to just watch TV instead.''

● The service was at risk of having a closed culture. People and staff felt unhappy and were not convinced that things would change for the better.

The provider failed to consistently assess, monitor and mitigate risks to people's health, safety and welfare or instil and promote a positive culture at the service. The provider had failed to improve the quality of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The regional manager explained they would be putting in more resources to help improve the service such as a clinical lead and a quality monitoring manager. They were confident that this would help drive improvements and put actions in place.

● Despite our concerns some people and relatives were positive about the culture of the service. One person said, ''I love it here. It has been my home for so long and we are a big family.'' A relative told us, ''I think all the staff are very polite and courteous and we have never had any issues.''

● The registered manager and management team were keen to improve the service, although they stated there was still a lot of work to do.

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

● People were not being engaged to give feedback about the service. Meetings were held with people; however, these were poorly attended. Minutes from these meetings showed a very negative response from the management team to issues raised by people. One person said, ''I feel like I need to give the other people living here a voice. They just sit here doing nothing and no one is doing anything about it.''

● Relatives told us they were not asked to feed back about the service. One relative said, ''We have not been asked to have a meeting and have had no questionnaires or anything like that.'' The registered manager had plans to engage more with relatives in the future.

● Staff attended meetings however minutes of these showed a negative culture between the management and the staff team. Staff told us they did not feel well supported by the management team and had found the constant management and staffing changes difficult to cope with.

● We received mixed feedback about the registered manager. People's comments included, ''The registered manager is putting improvements in place but only because they are scared, they will get in trouble. They do not care what we think'' and, ''I have no idea who the registered manager is. They are not dealing with the problems with staffing though.'' A relative said, ''My [family member] is not happy with the way the service is

managed at the moment.''

● We also received some positive comments. A relative told us, ''[Registered manager] is great and a breath of fresh air- they are trying hard to drive improvements.'' Another relative said, ''I think [registered manager] wants to get the service back to where it was.''

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 registered manager reported incidents to the local authority and CQC as necessary. They responded to people's concerns promptly and were honest with them if things went wrong.

Working in partnership with others

● Staff linked and worked with health professionals to help ensure good outcomes for people.

● The management team spoke about plans to start using volunteers to support people to leave the service and go to community events again following the COVID-19 pandemic.

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 9 HSCA RA Regulations 2014 Person-centred care |
| Treatment of disease, disorder or injury | People were not supported in a person-centred manner. People were not engaged throughout the day, and people's individual likes; dislikes and preferences had not been sought nor considered. |

**The enforcement action we took:**

Notice of proposal to cancel provider location and registered managers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect |
| Treatment of disease, disorder or injury | People were not receiving kind and compassionate care and were not being supported to be as independent as possible. This placed people at risk of not receiving respectful and dignified care. |

**The enforcement action we took:**

Notice of proposal to cancel provider location and registered managers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | We found no evidence people had been harmed. However, systems were not robust enough to mitigate risks, where possible to people's safety. |

**The enforcement action we took:**

Notice of proposal to cancel provider location and registered managers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The provider failed to consistently assess, monitor and mitigate risks to people's health, safety and welfare or instil and promote a positive culture at |

| | |
|---|---|
| | the service. The provider had failed to improve the quality of the service. |

**The enforcement action we took:**

Notice of proposal to cancel provider location and registered managers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>We found no evidence people had been harmed. However, there were not enough staff to support people in a timely manner or in line with their preferences and systems were not in place to ensure that staff had the support, training, skills and experience to support people safely. . This put people at risk of potential harm. |

**The enforcement action we took:**

Notice of proposal to cancel provider location and registered managers registration.