John-Edwards Care Homes Ltd

Bows

Inspection report

324 Frome Road
Trowbridge
Wiltshire
BA14 0EB

Tel: 012257744444
Website: www.activecaregroup.co.uk

Date of inspection visit:
21 May 2023
23 May 2023
24 May 2023
26 May 2023

Date of publication:
07 December 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Bows is a residential care home providing accommodation for up to 5 people who require nursing or personal care. The service provides support to adults under 65 years and people who have a learning disability and/or Autism. At the time of our inspection there were 5 people using the service.

People had their own rooms and the use of communal rooms, such as a lounge, kitchen, sensory room and dining area. There was a large garden to the rear of the service.

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

Right Support
Risks to people's safety were not always managed safely and we observed staff not always following risk management plans. This placed people at risk of harm. People were not supported to engage in their social interests and there was limited opportunity for people to access their local community and services. Staff were not encouraging or supporting people to achieve their goals.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. The policies and systems in the service did not support this practice.

People's medicines were not managed safely.

Staff had been recruited safely and recruitment at the service was ongoing.

Right Care
People's care was not person-centred and there was no evidence people had been involved in making decisions about their care. People's known communication methods were not always used by staff to communicate with people.

People's activity plans were not being used by staff to make sure people were occupied or engaged. People were not encouraged to carry out activities of daily living to maintain and develop skills.

There were not always enough staff available to support people in line with their funded care hours. This meant people were not able to go out at times as there were not enough staff on duty.

Right Culture
Changes in management had impacted on service delivery. There had been no leadership to guide and mentor staff to provide person-centred care. The service was easily identified as a care home from the road. There was a big banner on the fence advertising to the public the service was hiring staff. There were large industrial bins by the front gates and the front of the building had a sign with the providers name visible. This was not in line with the guidance Right Support, Right Care, Right Culture.

Safeguarding incidents had not always been reported to the local authority which placed people at risk of harm. Incidents and accidents had not been managed to make sure actions were taken to prevent reoccurrence. CQC had not been notified of significant incidents and events as required by law. Quality monitoring systems were not effective in identifying and driving improvement at this service.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 12 August 2022) and there were 3 breaches of Regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was prompted in part due to concerns received about low staffing numbers which was preventing people from going out into the community, 1 person's seizure not being managed safely and poor maintenance in bathrooms. We found evidence to substantiate some of the concerns received.

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

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to safe care and treatment, medicines management, person-centred care, safeguarding and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
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 of registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Bows

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
This inspection was carried out by 2 inspectors, 1 medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Bows is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Bows is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was not a registered manager in post. The provider had appointed a manager, but they had not submitted an application to become registered. We refer to them as 'the manager' in the report.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We communicated informally with 5 people who used the service about their experience of the care provided. People who were unable to talk with us used different ways of communicating including using Makaton, objects and their body language. 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 4 members of staff, the manager and the operations director.

We reviewed care and support records for 5 people, this included risk management plans, care plans, medicines records, menu plans, health monitoring information and records. We also reviewed incidents and accidents records, health and safety records and information, handover records, communication book, staff rotas, agency profiles, training data, 2 staff files for recruitment, service improvement plan and quality assurance records.

Following our site visit we also spoke with a further 4 members of staff and 5 relatives on the telephone about people's experiences of care received.

Inadequate

Is the service safe?

Our findings

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

At our last focused inspection, we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not always kept safe from abuse. Systems were not robust enough to make sure incidents were routinely shared with local safeguarding teams.
- We found a number of incidents recorded on the providers incident reporting system had not been managed safely. For example, incidents of unexplained bruising, 1 incident where staff had physically restrained a person and 2 incidents where 1 person had slapped another person had not been shared with local safeguarding teams. This meant the provider could not be assured actions taken to keep people safe had occurred in all cases.
- Systems were not in place to make sure people who self-harmed were safeguarded from the risk of abuse. There was no guidance in place for staff to follow when people were found with unexplained injuries. Whilst people were known to self-harm, guidance was not in place for staff to escalate and report significant injuries. This placed people at risk of further harm.
- We observed 1 occasion where a person experienced a distressed reaction which was preventable. During our inspection we were told about planned maintenance taking place. We found a plan had not been put in place to support 1 person whilst this maintenance was taking place. This meant the person returned to the service to find their bedroom occupied by the maintenance person which caused them significant distress. Whilst staff responded to the distress, it was preventable with forward planning and better communication.

The provider failed to have systems in place to safeguard people from the risk of abuse and improper treatment which placed them at risk of further harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relatives we spoke with told us they felt their relative was safe. Comments included, "My relative is safe because [they] would tell us if anything happens" and "I do think my relative is safe."

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

At our last inspection the provider failed to make sure risk management plans for people were clear and being followed which 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.

● At our last inspection we found risk management plans were not up to date, or clear, on the levels of support people needed. For example, 1 person required a 2 to1 staffing ratio which was not being provided at all times. At this inspection, this had not improved.
● Prior to our inspection we received concerns that low staffing numbers were impacting on people's care and support. We found evidence to substantiate that concern.
● One person was commissioned to have a 1 to 1 staffing ratio during daytime hours. We did not see evidence this was being provided. We observed the person spent time alone in their room or in their lounge. The risk management plan in place for this person's health condition required staff to call for medical help when needed after a specific amount of time. We were told of an incident where this person required medical help. This was not provided according to their risk management plan as staff were not providing 1to1 care at all times. This placed this person at risk of harm.
● Staff told us there were not always enough staff available. One member of staff said, "When we have numbers of staff we try and go out, we know it is not often. We have had issues with staff for a long time, people are fed up at the moment and don't want to do things anymore."
● We observed staff boiling vegetables on the stove in preparation for a meal at 09.30am. Once boiled, staff turned the heat off and left the pans with boiling water on top of the stove. This placed people at risk of harm. Staff told us people were never alone in the kitchen. However, we observed 2 people in the kitchen with no staff present on 2 separate occasions.
● Staff did not follow guidance in risk management plans when supporting people to eat. We observed 1 person, who was a known choking risk, eating alone. We also observed staff support another person to eat without following the specific guidance in their care plan. For example, staff had to sit alongside the person and make sure they had adapted cutlery. Staff did not provide the person the cutlery and sat directly in front of the person. Staff were also not to leave this person alone when eating. During our observation we saw staff left this person on their own with food. This placed people at risk of harm.
● Measures in place to mitigate known risks were not effective. For example, one person at risk of malnutrition and dehydration was having their food and fluid monitored and staff were not recording the amounts of food eaten. In addition, there was no consistency or targets for fluid consumption. Staff were recording fluid consumed at times in sips, by bottles or in mls. Staff had not added up fluids consumed so monitoring was inadequate.
● People at risk of malnutrition were not being weighed according to risk management plans. One person was to be weighed weekly; records demonstrated they had not been weighed for 5 months. Another person was to be weighed every fortnight. This had also not taken place.
● People were not fully protected from the risk of fire. People had personal emergency evacuation plans in place (PEEP). However, these had been written in 2020 and not reviewed since. At night, in an emergency, staff were to evacuate people to the house minibus which was parked on the drive. However, there was no contingency plan for when the minibus was not at the service, for example, if it was at the garage being fixed or serviced. Staff had not practiced fire evacuation drills and some staff told us they had not received training in fire procedures. This placed people at risk of harm.
● Staff had not been provided with training on how to support people to move safely. Some staff told us they had not received practical moving and handling training and records confirmed this. The new manager told us they were concerned about how staff were supporting people in and out of the bath. Staff told us this was not easy to do, and they had also raised concerns to previous management about this move. The new manager had contacted an occupational therapist to plan a visit to review moving and handling procedures for people.
● Staff recorded incidents and accidents and logged them onto the provider's incident management system. However, action to prevent recurrence was not recorded and at times had not taken place.

Failure to provide safe care and support placed people at risk of avoidable harm. This was a continued

breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had been recruited safely with pre-employment checks carried out.

Using medicines safely

● People's medicines were not always managed safely.

● Staff completed records when people took their medicines out of the service on social leave, for example if they were going out for the day. We found staff were not reviewing the records when the person returned. This meant the provider could not be assured medicines were administered as prescribed whilst the person was away from the service.

● Systems were not in place for staff to monitor people's health and wellbeing when medicines were administered to reduce anxiety. This meant the provider could not be assured the medicine was effective or that people were well following administration.

● People had individual medicines administration records (MAR). We found people's MAR did not have the same information as people's 'as required' protocols and people's care plans. Records were conflicting which meant the provider could not be assured staff had consistent guidance to follow.

● Where people were prescribed a variable dose or 'as required' medicines, protocols in place contained insufficient information. This meant the provider could not be assured people had their medicines as prescribed consistently.

Failing to manage medicines safely placed people at risk of avoidable harm and was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored in people's rooms where possible to encourage medicines administration to be in private when safe to do so. The service had identified the need for 1 fridge to store medicines, which had been ordered.

Preventing and controlling infection

At our last inspection the provider had failed to make sure robust systems were in place to ensure the infection control policy was implemented effectively. 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

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. At our last inspection we identified work needed for the environment to be maintained safely. Whilst some of the work had been completed, there were areas that still required attention.

● For example, one bathroom still had floor tiles with dirty grout and staff were using a rusty floor cleaner. The new manager took action to remove the rusty floor cleaner during our inspection and told us the provider had planned to refurbish the bathroom. We were told this at the last inspection and have found the action needed has still not taken place.

● At our last inspection, we found staff were not complying with the provider's infection control policy with nail extensions and nail varnish. At this inspection we observed 1 member of staff had yet to comply with this policy and still had nail extensions and nail varnish applied. The new manager told us the member of staff was waiting for an appointment to have them removed.

● The provider could not be assure staff were using PPE effectively and safely. We observed staff wearing gloves to carry out many different tasks without removing them and washing their hands. In addition, we also observed a member of staff remove their PPE in the kitchen and search around for a bin to dispose of them. This was not following the provider's procedures.

We found no evidence that people had been harmed. However, systems were still not in place or effective enough to ensure the infection control policy was implemented effectively. 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.

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

Visiting in care homes
● People were able to have visits from friends and family without restrictions.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

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

- People were not involved in planning and preparing all of their meals. We found menu plans recorded what the daily main meal was and who had chosen the meal for that day, which was 1 person per day. This meant for some weeks, people were only choosing what to eat for their meal once a week. Whilst alternatives were available, people should be encouraged to choose all of their meals every day.
- People were not involved in shopping for food. Staff told us they had 2 deliveries a week with groceries which was easier to manage. We saw in 1 person's activity plan they enjoyed doing food shopping with support. There was no evidence to demonstrate this person had the opportunity to be involved in grocery shopping. Staff told us they used to go to the supermarket to do the shopping, but this had stopped during COVID-19.
- People were not consistently provided with a healthy, balanced diet. We found in 1 person's care plan they were to have 5 portions of fruit and vegetables per day. We reviewed their daily notes and found they were not offered any fresh fruit or vegetables on some days. This meant their needs and preferences were not being met and people were not supported to eat healthily.
- People did not have health action plans in place. There was some guidance in people's care plans about their health needs, but no specific health action plan covering all health needs.
- Guidance from healthcare professionals was not always being followed. For example, 1 person had guidance in their plan from an occupational therapist (OT) to use a specific piece of equipment daily. Staff told us they did not use this equipment and there was no evidence in the person's notes that it was being used.

Failing to provide person-centred care that met people's needs and preferences was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Assessment of people's needs did not contain all information needed for staff to be able to provide good care. Nobody at the service knew what commissioned hours people had been assessed as needing. This meant the provider could not be assured care was being delivered to meet people's needs at all times. One member of staff said, "[new manager] is trying to sort out what hours people have. There was confusion about this, we need to know what the 1 to 1 entitlement is."
- Staff were not using nationally recognised assessment tools to identify risks. There were tools in people's records to assess risks of malnutrition, but these had not been completed correctly and were out of date.

Staff were not using tools to assess needs with regards to the risk of developing pressure ulcers. The new manager told us they were planning to introduce the 'Waterlow' assessment tool for staff to assess risks of developing pressure ulcers.
● There was no evidence in people's care plans people had been involved in assessments of their needs. Whilst there was some good information recorded in care plans, staff were not following the guidance.

Systems were not in place to assess, monitor and mitigate risks which placed people at risk of harm. This was a breach of regulation 17 (Good governance) 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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Staff were aware of the principles of the MCA but could not demonstrate they understood them at all times. We also heard staff talking with the new manager about relatives making decisions for people when people could make their own decisions.
● For one person, with an additional restriction, it was not clear what the rationale for the decision making was. We shared this with the operations director who said they would take action to review this record.
● People had MCA records which recorded the best interest process and who was involved. DoLS authorisations with conditions were being met.

Staff support: induction, training, skills and experience
● Staff training and supervision had not been provided consistently and to make sure staff were competent. We have reported on moving and handling training and fire training in the Safe key question.
● The new manager had identified gaps in training and had planned courses to provide staff with the skills and knowledge needed.
● Staff had not had regular opportunity for supervision. The new manager had identified this and carried out supervisions for some staff. They had a plan to make sure all staff had the supervision needed for effective support. One member of staff told us, "We do have supervision, but we have had a lot of changes in management. We used to have them every month, so [new manager] has put in a rota."

Staff working with other agencies to provide consistent, effective, timely care
● People had a hospital passport which recorded their needs. This went with people to hospital for emergency staff to know how to support people effectively.
Adapting service, design, decoration to meet people's needs
● People lived in a bungalow and had their own room. The provider had taken some action to improve the

environment, for example by carrying out maintenance.
● Rooms were personalised and reflected people's likes.
● People had access to a quiet lounge in the garden and a sensory room. This helped people spend time away from any noise in the main building.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last comprehensive inspection, we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; 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 encouraged to be as independent as they could be. People had goal plans recording what they hoped to achieve. We reviewed plans for 2 people and found they had not been evaluated since January 2023 and were not being used by staff to help people develop skills. For example, 1 person's goal plan recorded they wanted to be more involved in preparing their own meals. We observed 2 mealtimes when they were not encouraged to prepare a meal and found in their notes staff had recorded little opportunity for them to work to their goal.
- There was a culture at the service of staff doing things for people, not encouraging them to do as much for themselves as possible. We saw little evidence of people routinely being encouraged to complete activities of daily living and maintain independence.
- People had information in their care plans about their communication needs and how staff were to best communicate with people. This included using simple sign language such as Makaton and by using electronic tablets. We did not see evidence of either of these communication methods being used during our inspection.
- There was no evidence people had been involved in making decisions about their care and support and we did not observe people were involved at all times.
- Plans were not available in an 'easy read' format to help people understand and make decisions about their care.
- People's religious needs were not always being supported by staff. Where people had recorded in their plans they liked to go to church, staff had not always provided the right support. For example, 1 person liked to go to church on a Sunday, but they had not been to church for the month prior to the inspection.
- Staff did not have time to spend with people, sitting and talking with them or communicating in preferred ways. We observed staff were task driven, preparing food and meals without people and not taking time to involve people in all aspects of the service.

Failing to provide people with person-centred care that meets their needs and preferences placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were being supported and cared for by staff who enjoyed working at the service. Comments from staff included, "I love working here, I love that every day you come in, no days are the same" and "I enjoy it, I

like the [people], their personalities."

● Relatives told us some of the staff knew their relatives well and were caring. One relative said, "Some of the staff know [relative] well, the newer ones not so much. They [staff] are kind and caring and approach [relative] sympathetically."

Requires Improvement

Is the service responsive?

Our findings

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

At our last comprehensive inspection, we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

- People were not provided with person-centred care and were not consistently supported to access activities and local services in their community.
- Activity plans were in place but were not being followed. Staff told us this was due to a number of reasons including lack of available staff. Some activity plans did not have guidance for staff to follow in the evenings. We saw little evidence of people doing any activities during evenings.
- We did not find evidence in people's records that they had been able to take part in activities identified as being important to them. For example, 1 person had recorded in their plan they enjoyed going to the cinema, swimming and visiting the library. We did not find any evidence they had taken part in any of these activities. Staff told us they could not remember when they last visited the cinema or local swimming pool. Another person liked to go trampolining and had paid for lessons in advance. There was no evidence to demonstrate they were consistently able to follow this interest.
- For another person going out into the community was really important to their wellbeing. We reviewed their care records and found they were not supported to go out in the community consistently. Guidance also said they needed to have a routine and for staff to follow their activity plan. This was also not taking place.

Failing to provide people with person-centred care that meets their needs and preferences placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs had been recorded and there was a 1-page profile about how to meet the AIS. However, we found staff were not routinely using communication methods to engage with people.
- Records were not always available in an easy read or pictorial format so people could have support to understand information.

Failing to provide people with person-centred care that meets their needs and preferences placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● A complaints process was in place and 2 complaints had been received since the last inspection. Relatives told us they knew how to make a complaint and they had followed the process when needed. One relative said, "We have had concerns recently when previously we had none. We made a formal complaint regarding staff; we are still waiting for the full outcome."

● Complaints were logged, and the new manager told us they were investigating complaints received at the time of the inspection.

End of life care and support

● People had the opportunity to record end of life wishes if they wanted to. Information recorded on people's files had been shared by people's relatives.

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last inspection the provider had failed to make sure staff worked in person-centred ways which reflected people's preferences. 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.

● At our last inspection, we found staff were not providing care and support in a person-centred way. At this inspection we have found some areas had improved. However, care delivery was still not reflective of people's needs and preferences.
● Since the last inspection there had been 3 managers working at the service. Two previous managers had left the organisation and another manager appointed. Inconsistent leadership had been unsettling for this service and meant shortfalls had not been consistently addressed.
● Staff recorded in handover notes and in people's daily records they were unable to go out due to staffing numbers. One member of staff said, "We can't do a lot, we do 'in home' things when we don't have enough staff, [people] don't get what they need." This had not been addressed by the provider.
● The service had 1 minibus for all to use. Staff had to be over a certain age to drive which reduced the numbers of staff available. This impacted on people being able to access their local community and take part in their preferred activities. One relative said, "There are not enough staff on duty and not enough drivers." The new manager told us they were reviewing transportation to consider obtaining a car that more staff could drive.

Failing to provide people with person-centred care that meets their needs and preferences placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider failed to have systems in place to assess, monitor and improve the

service. The provider also failed to have systems in place to effectively respond to concerns. 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.

● At our last inspection we found the provider had failed to have effective systems in place to assess, monitor and improve the quality and safety of the service. Following the last inspection, the provider sent us an action plan which outlined action the provider would take to comply with regulations. At this inspection, we found actions had not been taken.
● For example, the provider told us 'Supervision will have a renewed focus on person-centred care. The new clinical supervisions will start from September 2022. Within this we will discuss residents care plan, individual preferences and unique needs'. Staff told us they had not been provided with 'clinical supervision' and the provider was not able to provide us with records to demonstrate these supervisions had taken place.
● Systems were not effective in identifying action that should be taken following incidents of safeguarding or concern. Notifiable events had not been shared with CQC. For example, we found an incident of alleged financial abuse which had been reported to the local authority, but not been notified to CQC. We found an allegation of neglect which had not been notified to CQC or shared with the local authority.
● Staff recorded some incidents on the provider's incident reporting system, but there was a lack of provider oversight which would have identified further action was needed. In the action plan sent to CQC following the last inspection, the provider told us, 'We will ensure we are scrutinising daily any incidents/ safeguarding or complaints, or areas of concern. This will be undertaken by the manager and senior every day'. This action had not been carried out.
● Systems in place to maintain oversight of the quality and safety and take action to keep people safe were not robust.
● On the first day of our inspection, we found a broken window. Staff had reported this window as being broken 1 month earlier. The provider failed to repair the window in a safe and timely way. The service had a hot tub which was out of action and had been for months. This impacted on people's wellbeing as they enjoyed using the hot tub. There was no clear plan of what was wrong with the hot tub and how and when it would be repaired.
● One person had bed rails in place. Staff had used the provider's risk assessment to identify and assess risks. This risk assessment informed staff if they answered 'yes' to 1 or more questions the bed rails were not safe to be used. Staff had answered 'yes' to 3 questions but were continuing to use the bed rails. We raised this with the provider during our inspection who took action to make sure the person was not at risk of immediate harm.
● We found guidance in people's care plans for staff to 'grade' any pressure ulcers they found using NHS guidance. None of the staff at the service were clinical and trained to carry out this clinical assessment. This placed people at risk. We raised this with the provider during our inspection.

Systems to ensure compliance with regulations, systems to assess, monitor and improve the service and systems to assess, monitor and mitigate risks relating to health, safety and welfare of people and others were not effective. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The new manager had developed a service improvement plan and identified some improvements needed. We were not assured all the improvements would be carried out with the available resources at the service.

For example, the new manager was planning to manage 2 services. Whilst they were recruiting for a deputy manager, they would be new in their post and learning a new job role. We were not informed of any support to be provided in the interim.

● Staff were positive about the new manager's approach. Whilst they had been at the service for a short amount of time they had started positively. One member of staff told us, "I think [new manager] will make the place good. She has a lot of knowledge and is approachable."

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

● Systems were not in place for people to share their views about the service. This meant they were not able to influence how the service was managed. Obtaining views from some people would not always be easy to do, however the provider had failed to try different ways of monitoring or obtaining feedback. For example, by carrying out observations of practice.

● Systems were not effective to support staff to raise concerns about other staff practice. Staff told us they had reported concerns but not seen any action taken. One member of staff said, "I have hopes it is going to get better. I think it is chaotic, we have an issue with staff, running low on numbers. We have an issue with a member of staff, we tried to talk with the manager and reported things a few times. Nothing got done."

The provider failed to have systems in place to seek and act on feedback for the purpose of continually evaluating and improving the service. Whilst we saw no evidence of harm, this was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to our inspection the new manager had met with most of the relatives. Comments about the new manager included, "The current manager is very empathetic and is resolving issues" and "So far, this new manager is good. I feel listened to. The previous manager was very full of themselves all the time."

● Staff were able to attend team meetings, through these had been inconsistent. Minutes were kept.

Working in partnership with others

● Staff worked with healthcare professionals to meet people's health needs. Staff recorded visits and outcomes in people's records.

● People had an annual health check, however, for some people this had been carried out on the telephone. Staff told us this was due to COVID-19 restrictions which had not yet been lifted.

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 new manager had been open and transparent with relatives about the service failures. There had been no incidents that were notifiable under the duty of candour.

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 The provider failed to ensure they provided person-centred care and support that met people's needs and preferences. Regulation 9 (1)

The enforcement action we took:

We served a Notice of Decision to remove the location from the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to make sure care and treatment was provided in a safe way, which included failing to assess and mitigate risks and failing to make sure staff had competence, skills and experience needed. Medicines had not been managed safely and risks for infection prevention and control had not been mitigated. Regulation 12 (1) (2) (a) (b) (c) (g) (h)

The enforcement action we took:

We served a Notice of Decision to remove the location from the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to make sure systems were in place to protect people from abuse and improper treatment. Regulation 13 (1) (2) (3)

The enforcement action we took:

We served the provider a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have systems in place to effectively assess, monitor and improve the quality and safety, assess, monitor and mitigate the risks relating to health, safety and welfare which placed people at risk of harm. Systems were not effective in making sure the service was compliant with regulations. The provider had failed to seek and act on feedback from relevant persons for the purpose of evaluating and improving the service. Regulation 17 (1) (2) (a) (b) (e)

The enforcement action we took:

We served a Notice of Decision to remove the location from the providers registration.