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Fouracres Care Services

Inspection report

47 Fouracres
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Tel: 02082924823

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13 December 2023
14 December 2023
20 December 2023
21 December 2023
29 December 2023

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
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
Fouracres Care Services is a care home providing accommodation and personal care for up to 6 people. The care home accommodates people who have a learning disability and older people. At the time of the inspection there were 6 people living in the home.

People's experience of using this service and what we found
Right Support
People were not supported to have maximum choice and control of their lives. Staff did not support them in the least restrictive way possible or in their best interests. The policies and systems in the service did not support this practice. There were restrictions on people's rights and freedom. We found people were expected to be in their bedrooms by 8.00pm and stay there until 8.00am. The provider could not demonstrate any rationale for this. The kitchen was locked and people were unable to access food for the rest of the evening until 8.00am the following morning. Staff on duty at night were on call but able to sleep. It was not clear how people could alert staff if they needed support or wanted to eat or drink at night.

People could not always choose how they wanted to spend their time. People had very limited opportunities to leave the home and take part in activities in the community. There was a lack of activities to take part in within the home and no opportunity to take part in any leisure activities in the evening. People did not receive support or opportunity to live an ordinary meaningful life.

Right Care
There were some positive caring interactions where staff were kind and supportive to people.

Staff had not been provided with any training in understanding what a learning disability is and how to and interact with people with a learning disability or autistic people.

There was no written assessment of people's care needs at night. Some people required support with continence. As there were no routine checks on people during the night it is possible that people could be left requiring support with personal care for up to 12 hours during the night. There were no call bells for people to get help from staff if they require personal care or if they were unwell. Staff relied on people shouting out to wake them up. The provider did not recognise the risks and poor quality of this practice and only took action to increase staffing when we pointed this out during this inspection.

There was no written fire evacuation procedure for night time and people were reliant on staff to leave the building in an emergency as the front door and back gate were locked. These concerns were addressed during the inspection but had not been identified as concerns by the registered provider.

Medicines were not always managed safely. People with serious medical conditions such as cancer and diabetes did not have written care plans detailing their health needs with guidance for staff to follow to ensure their health needs were met.

Right Culture
There was a lack of evidence of a positive person-centred culture which promoted people's rights and autonomy. The service was not able to demonstrate they were meeting the underpinning principles of right support, right care, right culture.

The environment was not homely as there was a poor standard of cleanliness in some rooms and broken and damaged furniture.

Management oversight was not effective. Although systems were in place to monitor the quality of care provided by the service, we found the audits carried out by the manager and the provider were not always accurate. They did not identify all the concerns that we found during this inspection about care plans, medicines management, financial management and the environment.

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

Rating at last inspection
At the last inspection we rated this service good (published 26 February 2022).

Why we inspected
The inspection was prompted in part due to concerns received about the management of people's personal finances. A decision was made for us to inspect and examine those concerns. We have found evidence that the provider needs to make improvements.

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. We found concerns about infection prevention and control measures as this the standard of décor and cleanliness and the condition of the furniture in the home did not meet infection prevention and control standards.

Enforcement and Recommendations
We have identified breaches in relation to providing person centred care, dignity, safe care and treatment, medicines management, safeguarding people from the risk of abuse, meeting people's nutrition and hydration needs, safety of the environment, infection control, staffing and the overall management and governance of the home.

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

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 the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Fouracres Care Services

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
The inspection team consisted of one senior specialist, one inspector, and, two pharmacist specialists.

Service and service type
Fouracres Care Services is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement dependent on their registration with us. Fouracres Care Services 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 a registered manager in post. The registered manager was away from work during the inspection.

Notice of inspection
We carried out the inspection visits on 13, 14, 20, 21 and 29 December 2023. This was an unannounced inspection. The visits on 21 and 29 December were announced at short notice to enable staff to be available to assist us with the inspection.

What we did before the inspection

Before our inspection, we reviewed the information we held about the home.
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 also looked at complaints made and any feedback from people using the service, their relatives and/or other professionals involved with the service. We used all this information to plan our inspection.

During the inspection
After the first day of the inspection, the provider and the registered manager were away from work for the rest of the inspection. The provider had asked a management consultant company to run the home in their absence. We met with the consultants on two occasions and they assisted us with the inspection by providing us with information we requested and acting on concerns we found.

We spoke with 7 support workers, the provider, a personal assistant and the 6 people living in the home. We spoke to 2 relatives of people living in the home and 2 professionals who were involved with the home. We spent time observing staff interactions with 4 people to help us understand the experience of people who could not tell us about their experiences. We also observed 4 mealtimes. We looked at 5 people's care records and medicines records for 5 people; we also looked at various documents relating to the management of the service. This included staff training, provider audits and health records.

We completed a tour of the building and we looked at medicines' management and food safety. We requested further information from the registered manager and provider which we reviewed as part of the inspection and we held a further meeting with them to discuss concerns.

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 inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were at risk of avoidable harm due to poorly maintained environment and equipment.
- One bedroom which was inhabited by a person with a physical disability had number of safety hazards. The window was not suitably restricted, the radiator was hot enough to cause scalding if the person were to fall against it and there was no radiator cover or risk assessment stating why the radiator was not protected.
- None of the bedroom radiators had been protected against people being scalded and there was no risk assessment in place to suggest that this was not needed.
- One room had an unidentifiable substance stuck to the wall next to the bed. We were told that this may have been on the wall since before this person moved into the room several months ago. This was unacceptable.
- One curtain pole was broken and a hazard to the person living in the room.
- A shower was damaged and a safety hazard.
- The showers provided in the home were not well suited to people with a physical disability who needed support in the shower. This is because they were too small and with a high step to enter them.
- Two chairs in use in the lounge was stained and dirty and one was also torn. The coffee table in the lounge was stained and damaged.

This failure to ensure safe environment and equipment was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Risks to people's health and safety were not always assessed to keep them safe from harm. There were risk assessments in place outlining risks to people's safety and advising staff on how to mitigate the risks however these were not comprehensive.
- Care plans contained minimal information about people's health needs, how their health conditions impacted on them and what support they needed from staff. Some people had serious health conditions such as diabetes, kidney disease and cancer. Staff were not provided with enough written information to support these people with their medical needs so there was a risk of them not receiving safe care and treatment.
- One person had a pressure care management plan to address the risk of pressure ulcers but others did not.
- The fire risk assessment in the home had not been conducted by a suitably qualified person. Some of the fire risks that we observed were not included in the fire risk assessment. People had personal emergency evacuation plans but these were not accessible to staff in the event of a fire. These records were stored in people's files and did not contain enough information about how staff could quickly evacuate the person

safely.
● Fire exits were locked with no instructions on how to ensure people could evacuate safely.
● There was no written fire evacuation procedure for staff to follow at night which left people at risk in the event of any fire or other emergency. A fire evacuation procedure was written by the provider's consultant during the inspection process.
● There were fire safety risks in the home. There was no risk assessment for smoking. We observed holes in two fire doors.

Preventing and controlling infection
●The service did not fully protect people from risks associated with infection.
● We observed that, although some rooms were clean, the lounge and the majority of bedrooms were not sufficiently clean to ensure people were protected from risk of infection.
● There were infection control risks throughout the home. There was no towel for hand washing in one person's bathroom.
● There were two sofas in use in the lounge and one in the covered area of the garden. Two of these sofas had several tears and all three were dirty. This was an infection control risk.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises due to trip hazards and dirty seating.

Using medicines safely
● Medicines were not always managed safely and effectively.
● The provider did not have appropriate systems for the delegation of the administration of insulin. Staff were administering insulin straight from the fridge which was not in line with good practice guidance. This placed the person at risk of experiencing pain during insulin administration.
● Blood glucose monitoring equipment was not being managed in accordance with the manufacturer's instructions.
● Records of medicines administration were not always an accurate reflection of the medicines that they were taking.
● Staff did not always take action to keep people safe when monitoring their physical health.
● Care plans were not sufficiently detailed to enable staff to look after people with diabetes.
● Staff did not keep records to monitor people for constipation. This placed people at risk of harm.
● Staff did not act when fridge or room temperatures were outside of the recommended range. The impact of this was likely to be minimal due to the medicines being stored.
● Staff were crushing a medicine that had been purchased over the counter into food for one person. However, no guidance had been sought on whether it was safe to do this. It is not possible to assess the impact of this.
● Records suggested that staff were unaware of the increased fire risks associated with the use of creams.
● Protocols to support staff in managing a particular 'when required' medicine were not always detailed enough to guide staff on managing variable doses.
● We were unable to establish if there were systems for the management of medicines incidents, medicines audits, or the management of safety alerts.

All the above was evidence of a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed the concerns about medicines immediately with the provider's consultant. They arranged for a suitable medicines fridge to be purchased.

● There were suitable arrangements for ordering, receiving, and disposing of medicines.
● The management of a person's diabetes was referred to the district nursing team after the inspection.
● Staff were trained and assessed as competent in the administration of general medicines.
● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autistic people or both).

Systems and processes to safeguard people from the risk of abuse
● The systems and processes in place did not fully protect people from the risk of financial abuse.
● The provider informed us that they had charged a person living in the home for use of clinical waste bins. This was inappropriate and without consent from the relevant persons.
● The provider could not demonstrate systems in place protected people who had been charged for the purchase of a clinical waste bin, food and household items such as toilet rolls, fabric conditioner and meats. One person's money had also been used to pay for a parking charge. There was no record people had given consent for their money to be used for these purposes.
● Records had been checked but the financial discrepancies had not been identified by the provider or the manager. Therefore they also had not been reported to the relevant authorities.
● The systems in place for auditing the expenditure of people's money were therefore not effective as these records had been checked and the financial discrepancies had not been identified by the provider or the manager.

This failure to operate effective systems to manage people's money appropriately left people at risk of financial abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were not effectively deployed to meet people's needs. Care workers were responsible for all cooking and cleaning as well as supporting people with their care needs and we observed they spent limited time engaging with people in meaningful activities.
● We were not assured there enough staff to provide safe staffing levels. On the first day of the inspection, we found that there was only 1 night staff on duty from 8.00pm to 8.00am. This worker was on sleeping-in duty which means they were asleep in the home on call.
● There was no dependency assessment or risk assessment available stating that this night-time staffing level was suitable to meet people's health and safety needs.
● This level of staffing meant there was a risk that people could not evacuate in the event of a fire and a risk that their care needs at night would not be met.
● Care records showed that some people had poor health and some people had needed support with continence. These people needed staff assistance to change their continence aids. The lack of routine checks from 8.00pm to 8.00am meant that these people were at risk of being left without personal care and continence support for 12 hours. During this 12 hour period, doors were shut and the kitchen was locked so people could not access food and drinks unless they had them in their room.
● Staff said that if people needed attention in the night they would shout for help. There were no call bells in place for people to get help from staff.
● One younger person who did not need support to go to bed was asked to go to his room and stay there for the hours of 8.00pm to 8 .00am.
● Staffing was not always planned in a way to meet people's needs and preferences. The day shift finished at 8.00pm and there was no opportunity and no record of any evening activities taking place or offered.

This was a breach of Regulation 18 – Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2022.

The provider increased the staffing level on the second day of the inspection to 1 staff awake at night which they told us was as a result of the inspection. After this date, the provider's consultant in the provider's absence increased the staffing at night to 1 staff awake and 1 staff asleep on call. This indicated that this was the level of staffing that people needed and had not previously been getting at night.

● After the inspection, we met with the provider and registered manager who told us that they would be sustaining the improved staffing level at night from now on. They also said they would be extending the day shift to 10.00pm to allow people to go to bed at the time they choose rather than for staff convenience.

Visiting in care homes

● The provider informed us there were no restrictions on people receiving visitors. Relatives did not report any restrictions on their ability to visit. Staff said 1 relative visited weekly.

Learning lessons when things go wrong

● Accidents and incidents were recorded but there was no evidence of learning lessons from incidents. We asked the provider how they used incidents and errors as learning opportunities to prevent future incidents. They gave the example of keeping better records as a result of ongoing concerns raised about the management of a person's money. However, we found concerns about the management of people's money which the provider said they were not aware of so we were not assured that lessons were always learned when things went wrong.

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 our last inspection we rated this key question good. At this inspection the rating 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
- We were not assured that all staff were suitably trained and supported to carry out their duties effectively.
- Records showed staff had completed mandatory training but this did not include any training on understanding what a learning disability is or training on interacting with people who have a learning disability or autistic people.
- There was no evidence of staff being trained to take blood glucose readings or administer insulin but staff were undertaking these duties.
- Recruitment records showed that 2 of the 3 staff who had been employed within the last year, were employed with no experience or training in the care field and the provider expected staff to pay for their training.

The lack of effective staff development in the form of training was a further breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Records showed 3 staff had a suitable qualification for their role. These staff showed good understanding and a commitment to the people in the home.

Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People were supported with access to health services, but some health needs may not have been fully met.
- People had hospital passports which were to ensure healthcare professionals would know important information about the person in the event they had to go to hospital. We noted the information on 1 person's passport was not up to date.
- Staff supported people to arrange and attend appointments with their GP and hospital consultants as needed. However, we were not assured their health needs in this respect were always fully met. We saw a letter stating that one person had missed a planned hospital treatment which meant they had this treatment late.
- For people with medical conditions, there was insufficient information about their condition, what symptoms they might experience, how the condition impacted on them and what action staff needed to take to support them with their health. Staff had not been given full information on people's health conditions so there was a risk people's health needs may not be fully met.
- Staff took health observations but had a lack of written guidance about what to do if a person's oxygen

saturation levels, weight or blood glucose level was of concern. We found 2 examples of observations which warranted medical attention which was not acted on.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Oral care was provided. We saw people had toothbrushes and their care plans detailed their oral health support needs, including their preferred toothpaste.
● Care plans also included people's preferred toiletries which was a example of people's preferences being addressed.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported with eating and drinking but their diet was not always nutritionally balanced.
● The menu showed some people were not offered any vegetables with meals. We observed some meals were not nutritionally balanced and some people were not offered a choice of what they would like. Only one person was supported to choose and help prepare their own meals.
● The records did not demonstrate people had been involved with planning menus.
● One person had eating and drinking guidelines written by a speech and language therapist due to having swallowing difficulties. We observed three mealtimes and saw that these guidelines were not completely followed to ensure safe eating and drinking. There were no checks by the registered manager or provider to ensure guidelines were fully understood and followed.
● Records showed two people should have fortified food. There was limited guidance for staff on how to provide appropriate fortified meals. For one person, staff added cream to meals but this was not always the most appropriate option. For example from reading food records and speaking to staff we found cream was added to meals such as pureed fishfingers, chips and baked beans.
● There was no dietician input requested by the provider to give guidance to staff. One person was at risk of malnutrition and had been underweight for a long time but no action had been taken to make a dietician referral. When this person was weighed during the inspection we found they had lost weight despite records indicating they had been the same weight every week for four months. This person's food records did not demonstrate they had sufficient support with their diet to maintain their weight.

This was a breach of Regulation 14 – meeting nutritional and hydration needs - of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff supported people kindly with their meals. One person liked salad and we saw they were supported to help prepare their salad and to tell staff what they wanted to eat.
● Another person was given some meals that suited their cultural preferences which staff cooked for them.
● The consultant told us that staff made good quality appetising meals on Christmas day which people enjoyed.
● The consultant made a dietician referral for the person who was underweight during the inspection when we raised a concern.

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. We checked 1 DoLS and there were no concerns. Another was authorised for 6 months giving the local authority time to find a home better suited to the person's needs and wishes. The DoLS were in date.
● Care plans lacked evidence of assessing people's capacity to make decisions and choices in their day to day life, for example whether they wanted to go out, go to bed at a specific time or only when they were ready to sleep.

Staff working with other agencies to provide consistent, effective, timely care
● Staff told us they worked well with the local care home assessment team matron.

Adapting service, design, decoration to meet people's needs
● The home's design did not meet the needs of some of the people living there. The bathrooms were small and the shower cubicles unsuitable for people who required assistance in the shower.
●There were maintenance concerns, which are detailed in the safe section of this report.
● The seating in the communal lounge was not suitable for some people who would not be able to get up easily from the sofas and the chairs they sat on were poorly maintained.
● There were no handrails in place for people with a physical disability. The building was not easily accessible for those people using walking frames due to trip hazards.
● The décor in several rooms was of a poor standard including dirty and stained walls.
● People had personal items in their bedrooms. One person's room was personalised and homely.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not fully assessed and met.
● People's needs were assessed before they moved into the home. The assessments contained limited detail about some needs, for example needs relating to medical conditions.
● Information in the assessment did not consistently form part of the person's care plan. For example, 1 person's preadmission assessment indicated they needed personal care twice during the night but this was not part of the person's care plan and waking night staff were not provided until introduced as a result of this inspection.
● Care was not delivered in line with Right support, right care, right culture statutory guidance and staff were not aware of it because the provider had not given any training to staff.
● Care staff worked hard to meet people's needs for personal care but a lack of effective leadership meant they were not supported to address people's wishes and preferences fully in a person-centred way in line with good practice.

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 inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel 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

- We observed the culture of the home was to follow daily routines rather than offer people the opportunity to have autonomy and independence to say what they would like to do that day.
- Staff went off duty at 8.00pm (to undertake sleep-in duty in the home) and staff told us people were expected to be in their rooms by this time and stay there until 8.00am, which was a restriction on their freedom and right to choose when they get up and when to go to bed.
- 1 person who staff said did not previously go to bed early was expected to stay in their room and had no opportunity to go out, get food, drinks or to smoke or use communal areas between 8.00pm and 8.00am.
- We saw 2 women in the home had the same short haircut. We were told they had their hair cut short at a local barber with no evidence of choice about who would cut their hair. 1 woman's hair was unevenly cut and their appearance was dishevelled on the first day of the inspection. We asked the provider who cut their hair and they said the local barber. This meant their dignity was not respected.

This was a breach of Regulation 10 – Dignity and respect- of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We saw people felt comfortable with staff. We observed staff interacting with people and found all staff to interact with people in a very caring, kind and respectful way at all times.
- Two people benefited from staff who could speak their first language and/or who understood their cultural food preferences. We saw that staff had formed good relationships with people.
- Some people's protected characteristics had not been properly assessed so staff were not familiar with their cultural and religious backgrounds and preferences. This was due to deficiencies in the assessment process.
- People said they liked the care workers and were treated well.

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

- There was little evidence of people being supported to express their views or be involved in planning their care. People's names had been typed onto their care plans indicating they had signed it when this was not the case. Their representatives' views were not recorded in the care plans we saw.
- Although people could communicate their preferences if staff were familiar with their communication styles these were not reflected in their records. It was not clear whether people had been involved in decisions about daily routines, whether they would like to be involved in daily living tasks, learn new skills or

take part in leisure activities.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- For a person who had sensory loss there were limited reasonable adjustments they may need to ensure good understanding. There was a pictorial communication board which we did observe to be used and staff were unable to communicate with the person using signs. They had not referred the person for Speech and Language therapy assessment to support better communication.

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's preferences were not fully assessed and they had limited choices and control in their daily lives. 1 example was the activity plans that were completed a week in advance and showed no evidence that people had been involved in them. Activities were limited to chatting, television, walking in the house and relaxing for most people. One person told us they did not have a good life and felt lonely. Another person said they were happy but we saw they did not have any meaningful activities organised by the home. Their lifestyle involved going to a daycentre and seeing their family which they enjoyed. Another person said they were happy. We saw they were spending their days on their computer which they really enjoyed but they were not given opportunities to do other meaningful activities.
- There was no evidence of people's cultural and religious needs being addressed in their daily activities.
- 1 person's care plan stated that they had not expressed any cultural or spiritual needs. It was not clear whether they had asked the person who would not have been able to communicate this information easily and no evidence they had asked the person's next of kin what their religious and cultural background and preferences were.
- Another person's assessment stated that their spiritual and cultural needs were not assessed.
- People did not attend places of worship and there was no record of whether they had opportunity to choose to do this.
- Staff engaged with people in the home. 1 person helped staff with daily cleaning duties and went to shops with staff. Staff talked with people and were kind. However activity records showed "activities" to be relaxing in lounge, chatting with staff and "walk inside house", none of which are activities.
- 2 people attended a day centre so had something to do during the day. 2 other people stayed in their bedrooms. 1 person engaged in solitary activities that they liked but had limited engagement with staff.

● There was no evidence of people taking part in leisure activities in the community. We asked people and staff if they had a choice to go to cinemas, theatres, cafes, pubs, sports events, shopping or to visit places of interest. They said no. It was not clear if people had been given any choice to have more opportunities other than staying in the home other than visit the corner shop and local barber.
● We observed a deaf person experienced social isolation due to a lack of communication plan. There were pictorial symbols available for staff to communicate with the person but we did not observe staff to use these to initiate contact with the person. Staff also said they had not been taught to understand the person' signs. The provider stated that this person did not use any sign language when this was not the case. The person was able to use sign language.
● 2 people said they would like to leave the home as it was not their choice to live there.

There was no evidence people were harmed but there was a lack of evidence that care met people's needs and reflected their preferences. This amounted to a breach of Regulation 9 – Person-centred care - of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person told us they loved Christmas, they had enjoyed a Christmas party in the home and showed us Christmas presents they had received. Another person also told us they had received Christmas presents they had liked.
● Staff supported people to spend time with their families where they had a family.
● On the second day of the inspection we stayed to see the evening routine and found everyone was in their bedroom by 7.40pm, most people had been supported to go to bed. We asked if people ever went out in the evening and they said no.

Improving care quality in response to complaints or concerns
● We did not find any evidence of improvements made in response to complaints or concerns. The only concern we were aware of, which was not recorded in the complaint record, was about the management of one person's finances. There was no evidence of improvements made in the management of finances since this concern.

End of life care and support
● The service was not yet prepared to meet people's end of life wishes and needs.
● Despite some people being older and unwell, the service had not developed end of life care plans to plan ahead for where people might prefer to be cared for during illness and at the end of life, what would be important to them and what their specific wishes and preferences would be both for end of life care and in the event of their death.

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 inspection we rated this key question good. 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider could not demonstrate they had systems in place engagement with people, families or professionals in 2023 to seek their feedback on the quality of the service.
- We found people with a learning disability did not have the lifestyle, opportunities or choices they deserved to lead a meaningful life in accordance with statutory guidance, Right Support, right care, right culture.
- The provider had not kept up with best practice guidance.
- There was no evidence of any recent leisure activities outside the home, meaningful person-centred activities in the home or any evening activities offered within the home. Audits of care plans had not highlighted any improvements needed to people's quality of life or choices. 1 person had expressed a goal to pursue an activity outside the home but there was no update in the care plan explaining why this had not yet happened.
- There was no evidence of any audits or assessments of the quality of the experience of service users living in the home. The culture of the home centred around daily routines and not the individual quality of life experience.
- This showed a lack of effective monitoring and failure to improve the quality of the service provided and experience of people in the home.

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

- We did not assess the provider's understanding of the duty of candour at this inspection.

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

- The provider did not have effective systems or processes in place to monitor the quality and safety of the service or to assess, monitor and mitigate the risks to the health and safety of people in the home and others.
- There were reports of medicines and environment audits in place which we saw during the inspection. However these audits were not effective as they had not identified or addressed significant risks and issues identified during the inspection.
- The provider told us the home was clean and tidy. We observed this was not the case. This showed

insufficient oversight of risks to the health, safety and welfare of people and staff.
● The medicine audit reports did not identify any of the medicines risks we found during the inspection.
● The audits of the environment carried out by the registered manager or provider did not identify any of the health and safety risks we found during the inspection.
● There was evidence of misuse of people's money that had not been identified through the provider's auditing processes in place.
● We saw from records that the provider's consultant had informed them in writing of various concerns in the home which needed to be improved but we found the provider had not yet made those improvements.

Systems had not been operated effectively to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This demonstrated a lack of effective monitoring of the safety and quality of the service. This placed people at risk of harm.

This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.