Inspire Neurocare Limited

Inspire Neurocare Worcester

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Inspire Neurocare Worcester is a specialist neurological care home providing personal and nursing care to 24 people aged 18 and over at the time of the inspection. The service can support up to 43 people. The home is split across two floors.

People's experience of using this service and what we found
Systems and processes to manage people's medicines were not always effective and people were not always supported to receive their medicines in a safe way placing them at risk of potential harm. People's wound care was not managed effectively which caused harm to people. Governance oversight and quality assurance systems were not robust enough to identify shortfalls and drive improvement. Lessons were not always learnt which caused repeated failings in management oversight.

The provider understood their legal responsibilities and when to be open and honest when things went wrong, however these incidents were not always shared with the CQC. The provider worked in partnership with other agencies.

People had care plans in place which provided staff with information about their needs and preferences and how they would like these to be met however, these were not always followed. People were supported to keep in touch with their family and friends through video and phone calls and had assistive technology to meet their communication needs. People had access to healthcare services.
A complaints procedure was in place and people and their relatives knew how to raise concerns, but these were not consistently actioned or responded to.

People did not always have access to community and vocational opportunities and expressed their wishes to be more involved in the local community.

The environment was homely, spacious in design and met people's needs. People were supported by caring staff, however, staff had not always received the training they required for their role to ensure people's healthcare needs were met.

People were supported in line with the principles of the Mental Capacity Act (MCA) 2005. People supported in the least restrictive way and in their best interests.

The management team were responsive to the inspection findings and feedback and took action during and after the inspection to improve some systems and action some of the concerns raised.

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 23 August 2023).
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
We undertook this targeted inspection to check whether the Warning Notice we previously served in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

We inspected and found there were concerns with medicines, wound management and leadership and governance, so we widened the scope of the inspection to become a comprehensive inspection which included all of the key questions.

The overall rating for the service has changed from requires improvement to Inadequate based on the findings of this inspection.

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

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

Enforcement
We have identified breaches in relation to safe care and treatment, staffing, nutritional and hydration needs, receiving and acting upon complaints and 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.

Since the last inspection we recognised that the provider had failed to meet the actions of the warning notice. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Follow up
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**

Inspire Neurocare Worcester

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 was carried out by 4 Inspectors and a specialist pharmacist. An Expert by Experience made calls offsite following the 4th day of inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Inspire Neurocare Worcester 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. Inspire Neurocare Worcester is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This 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 who was on planned long term leave. There were management arrangements in place to cover their absence.

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

During the inspection
We spoke with 4 people using the service and 8 family members. We spoke with 14 staff members including the interim home manager, interim registered manager, interim clinical and project lead, quality service lead, maintenance operative, regional operations manager, director of operations Inspire, director of care, head of learning and development, and nominated individual, 2 care workers and 4 nurses. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records in relation to 6 people's care, including medication and care records. We also reviewed a range of records held by the service including, staff training and rotas, recruitment records, temporary staff records, meeting minutes, surveys, handover documents, provider audits and premises checks.

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 inadequate. At this inspection the rating has stayed the same. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had not ensure people received their medicines safely. This was a breach of regulation 12(1) 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. The provider had not met the requirements of the warning notice.

Using medicines safely

- The provider failed to ensure people received their medicines as prescribed and in a safe way.
- Staff were still not always following national good practice guidance when supporting people with their medicines. For example, best practice guidance recommends medicines administered through patches on their skin should have the site of the patch rotated. This was not happening.
- We found multiple gaps in medicines administration records (MAR). Some medicines were not administered as prescribed which resulted in people receiving duplicate doses or missing their medicines.
- We could not be assured the provider was supporting people safely to self-administer medicines. One person told us, "I self-medicate, sometimes staff are there when I have my controlled drug, sometimes they're not."
- Family members shared concerns in relation to the frequency of medicines errors. One relative told us, [person] had suffered from 7 medication errors. "They have forgotten their patch, given them one dose of antibiotics a day instead of two and gave their night medicine in the day." Another relative told us, "There have been 3 incidents in the last 2 to 3 weeks. I mentioned [person] didn't seem very with it and I was told that he was given 5.0 rather than 2.5 of their medication.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. Staff did not follow best practice when working at Inspire Neurocare and people did not receive their medicines as prescribed. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to ensure risks to people had been effectively identified and mitigate. This was a breach of Regulation 12(1) 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. The provider had not met the requirements of the warning notice.

Assessing risk, safety monitoring and management

- The provider had not assessed risk to ensure people's safety
- The provider had pain assessment tools in place for people to be followed before administering painkillers. However, we found pain assessment tools were not always used according to guidance or care plans.

●People's skin integrity was at risk of deteriorating due to poor oversight of care in this area. People's care plans showed their wound treatment was overdue or not carried out with frequency stated within people's care plans.
●We identified wound management plans had been completed but no action had been taken to protect a person from avoidable harm. For example, a person had required a change of PEG, (percutaneous endoscopic gastrostomy) the provider did not hold additional PEG stock onsite which resulted in them having a temporary PEG fitted. This was an interim measure until PEG stock became available. The provider had taken no action to ensure the persons correct PEG was fitted in a timely manner which resulted in the person developing sore skin. This had been documented in the persons daily notes but not shared or actioned by the provider. This caused harm to the person.
●Risks associated with storage of chemical products had not been effectively managed. During our inspection we repeatedly found, chemical products left in unlocked places so people could gain access to them. We found the sluice room containing products hazardous to health were left open on the fourth day of our inspection.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider carried out the relevant equipment and safety checks in line with good practice.

At our last inspection the provider had failed to ensure risks to people had been effectively identified and mitigate. This was a breach of Regulation 12(1) 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.

Learning lessons when things go wrong
●Lessons were not always learnt when things went wrong.
●For example, when medicines errors occurred they were not always recorded or investigated. Limited action was taken to address the issue of multiple medicines errors. For example, the service has introduced clinical care sheet. However, this tool proved to be ineffective as checks were not always carried at night or early morning which resulted in late reporting. Managers did not have oversight therefore were not always investigating medicines errors.
●The service failed to make improvements regarding safe storage of medicines and COSHH products, despite this being brought to the management's attention during onsite visits.
●Fridge temperatures were not being consistently monitored.

The provider had failed to ensure the health, safety and monitoring of risk. This placed people at risk of harm. These issues constitute a continuous breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We shared this information with the senior management team who started to take action and investigate the concerns. The provider implemented contingency plans and training for staff to provide assurances and mitigate further risk.

Staffing and recruitment
●The provider did not always operate safe recruitment processes.
●The provider failed to ensure that all agency staff had suitable training and checks in place before allowing

them to work with people. The provider had not completed Disclosure and barring service (DBS) check or the nursing and midwifery council (NMC) registration checks for 11 agency nurses who had worked with people over a 2 week period. This means we were unable to check the other 6 agency nurses for their NMC registration status. We checked 5 agency nurses' registration status with NMC, and one agency nurse showed as 'no results found' on NMC registration check.

Systems were not in place to ensure staff had the up to date knowledge, skills and healthcare training to deliver effective care. This placed them at increased risk of harm. This was a breach of regulation 19: Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We shared this with the management team who started to take action to obtain the relevant information to ensure agency staff had the relevant checks before continuing with further shifts.

●The provider told us they were actively looking to recruit nursing staff and had reviewed nursing salaries to encourage people to apply.
●Staff who were permanently employed at Inspire Neurocare were recruited safely into the service, the relevant safety checks before commencing employment had been obtained.
●We saw staff there were enough staff on duty to support people living at Inspire Neurocare.

Systems and processes to safeguard people from the risk of abuse
●People were not always safeguarded from abuse and avoidable harm.
●Managers understood their legal responsibilities to protect people and share important information with the local authority and CQC. However, we identified several recent incidents had not been reported or shared with the local authority. This was raised during the onsite inspection and the relevant referrals and documentation was submitted.
●We received mixed responses from people in relation to whether they felt safe. One person said, "They are over reliant on agency staff. They're not always very good, sometimes they haven't got a clue". Another said, "I generally feel safe. The staff are all very competent. On the night shift, there aren't enough staff. There are only 2 people on the first floor."
●Family members told us they felt their relatives were safe. One relative said "[person] says they feel safe there. One of the problems is that they can't keep staff. [person] has a designated carer which means they have more continuity."
●Staff told us they knew how to report abuse and were aware of the service's policy and would speak with the managers if they had any concerns.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was 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
● The provider was facilitating visits for people living in the home in accordance with the current guidance.

Relatives were happy with the visiting arrangements.

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 as requires improvement. 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

- The service did not ensure staff had the skills, knowledge and experience to deliver effective care and support.
- The provider failed to ensure that all nurses completed specialised training such as percutaneous endoscopic gastrostomy (PEG), epilepsy management or Buccal Midazolam administration training. We were not assured staff deployed had necessary skills and qualifications to provide care and support to the high needs of the vulnerable people living at Inspire Neurocare
- The provider used a high number of agency staff. These staff members had not received any induction and did not always have time to complete shadowing. There was a risk agency nursing staff would not be equipped with the necessary information and knowledge to do their job safely and effectively. We raised this on the second day of inspection with the provider who told us all agency nursing staff will go through induction at the beginning of their shift. On the third day of our inspection, we saw completed agency nursing staff induction forms, however, the dates of the induction did not always correspond with agency nurses on shift.
- During the inspection visits the provider was unable to demonstrate temporary staff received induction processes or shadowing shifts. We reviewed concerns in relation to temporary nursing staff medication errors and not following specific healthcare protocols. These had not always been discussed with the nursing agency. For example, 1 person had received the incorrect dose of nutrition feed, this had not been identified by management staff. The provider was not able to provide a response from the agency.

Systems were not in place to ensure staff had the up to date knowledge, skills and healthcare training to deliver effective care. This placed them at increased risk of harm. This was a breach of regulation 18 (2) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sourced the relevant training for staff during our onsite visits and obtained profiles for all planned agency staff. The provider reviewed agency staff training programmes and rescheduled their rotas to ensure staff had the relevant training for each shift to meet people's healthcare needs.

- Permanent Inspire Neurocare staff received an induction programme and shadowing shifts before commencing their roles.

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

●People's needs were not always assessed, care and support was not always delivered in line with current standards. People did not always achieve effective outcomes.
●People did not have their oral health supported in line with national guidance and best practice. For example, one person's care records stated the person was offered oral care only once within the last 28 days.

The provider had not ensured people's care was person-centred. This was a breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People told us they were not always involved in the reviewing of their care plans, one person told us, "There used to be a nurse on my floor who wrote my care plan with me but she's not on my floor anymore. I don't know what's in it now." "I'm on a rehab program. I have lots of physio and I'm making good progress."
●The provider had an initial assessment process which gathered information about a person's support needs before providing care. This also included staff from the therapy team assessing and completing transition work.

Supporting people to eat and drink enough to maintain a balanced diet
●People were not always supported to eat and drink enough to maintain a balanced diet.
●The provider had failed to take timely action when a person experienced significant weight loss. There was no evidence of a dietitian or external professional being involved in this person's care until their weight was over a 30% loss. Another person lost 6kg between July and August. However, the person's weight for September was not recorded to check if they were still losing weight.
●There were fluid monitoring charts in place setting hydration targets for people. However, there was no evidence of any action taken where people did not reach their targets.
●Family members shared concerns about inconsistent management with nutrition feed regimes. One family member told us their relative was not receiving the correct dose of nutrition feed. The persons intake was too low and they required additional supplements to ensure they received enough calories.

The provider had not ensured the safe management of people's nutritional and hydration needs. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We shared our concerns regarding people's hydration needs not being met with the management team who said they would review people's fluid monitoring charts.
Action was taken by visiting external professionals during our onsite visits to ensure the person received additional supplements where needed.

●Some people had access to snacks and drinks throughout the day in communal areas.
●The provider was hosting an afternoon tea on our last onsite visit where there was a range of cakes available for people and relatives.
●Feedback about food was positive from people, comments included, "We have new chefs, and the food is now outstanding." "Generally, meals are pretty good. I can have snacks and drinks when I want."

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support
●The provider did not always ensure the service worked effectively within and across organisations to deliver effective care, support and treatment.
●The system of communication between staff and external health professionals needed to improve to

ensure people received consistent, effective and timely care. For example, there was no evidence of the service provider contacting other healthcare specialists where people experienced significant weight loss.
●People were supported to access some healthcare services such as GP. However, referrals were not always made for people when their needs had changed.
●The home had an internal therapy team. People received various levels of support through rehabilitation programmes for speech and language therapy (SALT), physiotherapy and psychology.

Adapting service, design, decoration to meet people's needs
●The dining areas were designed to encourage social interaction. For example, dining tables were small to encourage conversations at mealtimes.
●Peoples rooms were personalised, homely and represented their hobbies, choices and preferences. There were quiet areas and communal lounges for people to access throughout the building.
●The structural design of the home was accessible for people using wheelchairs and enabled people to freely move around at their leisure.
●Bathrooms had been modified with specialist equipment, this included spa's, sensory lights, and enabled people to play their own music.
●There was an independent living flat for people to use as part of their rehabilitation when they are preparing to transition back into the community.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

●The provider was working within the principles of the MCA.
●People's capacity was assessed before they moved to the home and their care plans stated whether they had capacity to make decisions. People who were subjected to DoLS had approved DoLS authorisation certificates in their files. Where people were waiting for their DoLS to be authorised there was evidence of the service regularly checking progress of the DoLS applications. People's care files also had signed consent to care and treatment forms confirming agreement with their care and support plans.

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

Supporting people to express their views and be involved in making decisions about their care
- People were not always support to express their views and make decisions about their care
- Some relatives had been involved in care plans and decision making for their family members, others had not and were unaware of where, or what the care plan detailed.

The provider had not ensured people's care was person-centred. This was a breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We saw some care plans were out of date and required reviewing. People told us they used to have reviews with staff, but this has not happened for some time and they were unsure what their care plans entailed.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
- People were not always well supported and treated with respect by staff
- We received mixed reviews from people living at the service about their care. One person told us, "The staff ask for consent for my personal care. They are always respectful." Another person told us, "Some staff will ask for consent for care, others won't. Some staff are respectful and kind, others are detached and treat you as a job rather than a person. Some staff know me really well. Some aren't interested in me as a person, I'm just a job to be done."
- Relatives told us, "Carers are good, they do their best, they care about people". "On the whole, the staff are generally OK. The permanent staff are very good. There are a good team of staff. The Speech and Language and OT staff are fantastic. There are a good number of reasonably well-educated staff."
- We observed positive interactions with staff treating people with dignity and respect, we saw staff knocked people's doors before entering and asked them if they were ready before completing a task. One person told us that staff are considerate when completing personal care, they ask permission and explain what is happening throughout the process.
- Some people living at the service were completing rehabilitation programmes, this involved staff assessing, promoting and enabling people's independence skills. For example, the onsite independence flat offered people the opportunity to work on developing their independent life skills to prepare them to for a less supportive environment.
- People's cultural and religious beliefs were considered as part of people's care planning.

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.

Improving care quality in response to complaints or concerns

- People's concerns and complaints were not always listened to, responded to and used to improve the quality of care.
- There was a current complaints procedure in place. Staff had raised verbal complaints about lack of leadership in meetings. These had been documented but there was not always evidence to demonstrate a response to the concerns. Some staff told us they had shared complaints but did not feel these had been listened to or acted upon.
- One person told us "I raised a complaint over a week ago but I've had no response. Another person told us "If I complain to the shift leader, I'm reliant on them to pass it on." "There was a meeting but it was very one sided. Management don't really listen to what we say."
- Relatives told us, "There have been a number of family meetings but nothing ever happened from them. No one is leading the place. There's no one to speak to, to get anything changed." "If I have a problem, they'll know about it. Communication is not very good. They don't return calls."
- We reviewed complaints which the service had received, they evidenced a process had been followed to provide a response. However, some of the concerns shared with us through our monitoring and our onsite inspection was not documented in the complaints file.

The provider had not ensured people's and relative's concerns and complaints had been responded to. This was a breach of Regulation 16 (Receiving and acting on complaints) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The complaints received during inspection was shared with the management team who said they would take action to address them.

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

- People were not always supported as individuals, or in line with their needs and preferences.
- Records of people's care and support were not always reviewed regularly or delivered in line with best practice. Although some care plans offered detailed information, we identified shortfalls in care plans and daily notes.

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

- There was a lack of meaningful activities organised for people living at Inspire Neurocare. Daily logs showed people were mostly left on their own with minimum social interaction and little evidence of outdoor

activities.
●People had their likes and dislikes recorded in their care plans, however, there was no evidence of the provider using people's likes and hobbies to facilitate any activities. For example, one person's care plan stated they like classic cars and motorbikes. There was no evidence of any indoor or outdoor activity offered to this person related to their hobbies. Another person told us they were a keen supporter of a football club. We saw no evidence of this being used in provision of activities.
●People told us they would like to access the community more, one person had only accessed the community twice in 10 months and had shared this with the management team but no efforts had been made to facilitate community or vocational opportunities.
●We observed some internal activities taking place during our onsite visits, this had improved since our last inspection in June 2023. However, there was a lack of opportunities for people to experience vocational opportunities and rehabilitation outside of the service.

The provider had not ensured people's care was person-centred. This was a breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We shared our feedback from people with the management team who told us they would look at options for people to be offered the opportunity to access the community more.

End of life care and support
●No people currently living at the service required support with end-of-life care at the time of the inspection.
●There were systems in place to record people's advanced wishes. These included people's choices regarding resuscitation in the event of a cardiac arrest and treatments they would want to have in an emergency. However, people's wishes and preferences regarding end-of-life care were not always recorded. For example, information was missing about people's preferences such as symptom control, if they would like to be buried or cremated, funeral arrangements or after death care.
We spoke with the senior management team who told us they would start actioning this without delay.

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.

●The provider was meeting the Accessible Information Information.
●People had individual communication plans which detailed effective and preferred methods of communication and this was detailed in people's care plans including the approach to use for different situations.
●We observed people using different methods of technology to enable them to communicate with staff.
●Staff had good knowledge of people's preferred communication methods and how they could support people to use them independently.

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 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.

At our last inspection the provider did not have effective systems in place to monitor and drive good and safe care provision. This was a breach of regulation 17 (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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

- Measures to monitor the quality of the care provided were not always effective, this meant the management team did not have a full oversight of issues at the service to drive improvements. For example, the provider's medicines audits failed to identify issues related to medicines errors and measures introduced to address this issue remained ineffective.
- There were no effective systems or processes in place to ensure the records of peoples' needs and risks reflected their current care needs. We found multiple care plans and risk assessments being out of date. Some records were incomplete, out of date or missing. For example, the provider could not locate MAR charts for 2 people for 3 months prior to our inspection.
- The provider's systems had failed to ensure the staff deployed had the skills and experience required to perform their role. This placed people at increased risk of harm
- The provider failed to have management oversight when incidents occurred with people's specific healthcare needs. For example, 1 person had potentially received 4000mls of nutrition feed, this is 6 times more than they should have had. This was identified by an inspector on our onsite visit. Managers were unaware of the incident despite it being logged in the persons care notes.

The provider failed to ensure systems and processes were in place to assess, monitor and ensure management and clinical oversight of the service. The providers failings had caused harm to people. This was a continued breach of Regulation 17, (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We shared these concerns with the management team who started to take action to address these issues with immediate effect.

- Clinical and therapy meetings took place on a regular basis to monitor people's rehabilitation and therapy progress. Actions and goals were discussed for each person on a regular basis.

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

●There was not always a positive and open culture at the service. The provider did not always have effective systems to provide person-centred care that achieved good outcomes for people.

●We received negative feedback from people and staff regarding the leadership of the service, relatives expressed their concerns about their loved ones. One relative said, "The management is abysmal. There is a blame culture not a team culture. There have been problems for the last 6 months, all down to management, and it's got progressively worse." Another relative told us, "It hasn't been well led, not for some time."

●People living at the service told us, "The management constantly changes." "We're on the 4th manager. There's no joined-up thinking. It's a shame. The facility is not being made the most of. With better management, it could be absolutely superb."

●We found, although effective management systems were lacking, staff were positive when interacting with people. Despite sharing their concerns with inspectors, they told us they were invested in driving improvements at the service to enable better outcomes for people.

●Overall, we observed good interactions with staff and people living at the service and staff shared their knowledge of people's choices and preferences.

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

●People and staff were not always involved in the running of the service.

●Staff were not working as effective teams, ensuring mistakes in practice were identified quickly and confidently and brought to the attention of their colleagues or members of the management team where required. Where reflective meetings were organised by the provider there was no evidence of agency staff being involved.

●Feedback from staff had been obtained through staff meetings and surveys. Staff survey responses were mostly negative when asking for feedback about leadership and management. For example, 68% of staff said they felt management were not visible within the home. 72% of staff said their line manager was not supportive or approachable. 86% of staff said the management do not take notice of or act upon their comments.

●Despite the concerns which had been raised by relatives, the provider had a compliments file where relatives had shared their thanks regarding some of the care provided to their loved ones. For example, thanking the team for the help and support through a person's rehabilitation programme, and support provided to a person when they needed to be escorted to hospital.

●One family said they would recommend Inspire Neurocare to others, as the service was very welcoming. Another relative told us they would recommend Inspire Neurocare, but not at the moment, until improvements had been made.

Continuous learning and improving care

●The provider failed to identify trends and patterns of medicines error and incidents. Most of the medicine's errors occurred during weekends when the service was staffed mostly with agency nurses without clinical oversight of the provider.

●We could not see whether the service was committed to continuous learning and improving care. The overall quality of care had declined since our last inspection.

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 managers understood their responsibility to be open and honest when things had gone wrong,

however not all concerns had been addressed and some people and family members had not received responses to concerns which had been raised.

Working in partnership with others

- The provider did not always work in partnership with others.
- There were 8 occasions in August 2023 where temporary nursing staff had made medication errors which were not shared with the nursing agency. Actions had not been taken to ensure temporary nursing staff had had their competencies revisited which placed people at increased risk of harm.
- The staff team worked with other organisations including GP's, local hospitals, neuro-teams and dentists. We discussed this with the provider who agreed to look for ways to improve the communication with agency nursing staff to ensure staff received inductions, shadowing and were given sufficient information about people's complex health and support needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to robustly assess the risks relating to the health safety and welfare of people. Staff did not follow best practice when working at Inspire Neurocare and people did not receive their medicines as prescribed.

The enforcement action we took:

We asked the provider to take urgent action to address these concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	The provider had not ensured the safe management of people's nutritional and hydration needs.

The enforcement action we took:

We asked the provider to take urgent action to address these concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	The provider had not ensured people's and relative's concerns and complaints had been responded to.

The enforcement action we took:

We asked the provider to take action to address these concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to ensure systems and processes were in place to assess, monitor and ensure management and clinical oversight of the service.

The enforcement action we took:

We asked the provider to take urgent action to address these concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Systems were not in place to ensure staff had up to date knowledge, skills and healthcare training to deliver effective care.

The enforcement action we took:

We asked the provider to take urgent action to address these concerns. We imposed conditions on the providers registration.