

G P Homecare Limited

Radis Community Care (Maritime House)

Inspection report

Maritime House
Conan Road
Portsmouth
PO2 9DT

Website: www.radis.co.uk

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22 June 2023

23 June 2023

28 June 2023

12 July 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?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Radis Community Care (Maritime House) is an extra care housing service providing personal care to people. The service provides support to people with a range of needs including people living with dementia, older people, younger adults, and those with a physical disability. At the time of our inspection there were 67 people using the service.

People using the service lived in self-contained accommodation within a large purpose-built shared building of 80 flats close to Portsmouth.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found

Risks to people were not consistently assessed, and risk management plans were not always in place which put people at significant risk. Safeguarding concerns were not always identified or addressed quickly enough to protect people from avoidable harm. There were insufficient staff deployed to ensure people's needs were safely met. People's medicines were not managed safely. Infection control risks were not always managed safely. Lessons learnt were not effectively shared when things went wrong to prevent a reoccurrence.

People were not supported to have maximum choice and control of their lives. The provider's policy was not followed by staff and systems in the service did not support this practice.

Staff training, supervision and quality checks were not carried out routinely in line with the provider's policy which meant people may be cared for by staff without the appropriate knowledge, skills, and support. People's needs in relation to eating and drinking were not assessed or monitored to ensure their safety and wellbeing. The service did not always work effectively with other agencies to promote positive outcomes for people. We have made a recommendation about this.

People and relatives told us staff were kind and caring, however we also received feedback that staff could be impatient and rushed due to time constraints. Staff knew how to treat people with dignity and respect, but people's needs and rights in relation to decision making and communication were not always supported effectively. We have made a recommendation about this.

People's care needs were not always reviewed or up to date in their care plans. There was insufficient guidance for staff on how to meet some people's needs. Most people who could tell us about their care needs said they were met but records to support this were not always completed. Care planning for end-of-life care required improvement to ensure people's needs and preferences were considered, recorded, and

met.

Governance arrangements were not effective, and leadership was inconsistent. The provider had not operated their quality assurance systems effectively to ensure the service was safe and people received high-quality person-centred care.

Staff were recruited safely and staff new to care completed an induction. People told us their independence was supported and, those who were able to participate, enjoyed activities provided by the service.

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

Rating at last inspection

This service was registered with us on 12 August 2021, and this is the first inspection. The last rating for the service under the previous provider was good, published on 10 October 2018.

Why we inspected

The inspection was prompted in part due to concerns received about unsafe care including an allegation of neglect of a person, medicines errors, and staffing issues. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. The overall rating for this service is Inadequate based on the findings of this report.

Enforcement and Recommendations

We have identified breaches in relation to safe care and treatment, safeguarding people from abuse, staffing, leadership and governance, need for consent and providing person-centred care.

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

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?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate ●

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement ●

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-led findings below.

Radis Community Care (Maritime House)

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

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

Service and service type

This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

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 were two registered managers in post. We have referred to 'a registered manager' in this report because we spoke with both registered managers.

Notice of inspection

This inspection was unannounced. Inspection activity started on 22 June 2023 and ended on 25 July 2023. We visited the service on 22, 23 and 28 June and 12 July 2023.

What we did before inspection

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

During the inspection

We observed interactions between staff and people in communal areas. We spoke with 16 people and 14 relatives about their experience of the care provided. We spoke with 10 staff including 7 care staff, the service manager and the two registered managers (regional manager and support manager).

We looked at the care records of 11 people and multiple medication records. A variety of records relating to the management of the service were reviewed. These included policies and procedures, records of accidents or incidents, staff training and quality assurance records. Following the inspection, the registered managers provided us with information and other documents to support our inspection.

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Although most people told us they felt safe, we identified the provider had not completed specific care plans and risk assessments where required. This meant staff were not always provided with the guidance they needed to ensure people were provided with safe and consistent care.
- People at risk of skin damage and pressure ulcers did not have a risk assessment in place to provide guidance to staff on how these risks were to be managed or mitigated. For example, one person had developed pressure ulcers but there was no corresponding risk assessment or care plan to ensure the safe management of pressures ulcers for this person. Although this person had repositioning records in place there were no details for staff on how often the person should be re-positioned. The repositioning record did not demonstrate the person was re-positioned consistently. This meant their injuries could worsen.
- We identified within another person's care record they had a history of 'severe' pressure ulcers. It was confirmed by the manager and 3 staff members at the time of the inspection this person had a pressure ulcer. However, there was no risk assessment or care plan in place to provide guidance for staff on how to prevent pressure injuries. On review of this person's daily records, we could not be assured this person was receiving regular support to change their position. The lack of guidance and supporting records meant we were not assured risks were well managed, and this injury may have been preventable.
- We asked the manager about how the risk of pressure ulcers was assessed, and they told us there was no risk assessment or care plan in use by the service in relation to pressure area care. The lack of risk assessments, guidance, and training for staff in relation to pressure area care meant we could not be assured people had received safe and effective care. This placed people at significant risk of harm.
- Risks to people from choking were not managed safely and people were at significant risk of harm. On review of care records and discussions with staff we identified 5 people being supported by the service were at risk of choking. There were no risk assessments or care plans in relation to choking for any of these people. This meant staff were not provided with detailed guidance on how risks of choking could be managed and mitigated.
- We observed 1 of the people who was identified as at risk of choking holding food in their mouth during lunchtime, which increases the risk of choking. This person's nutrition care plan stated the person was unable to eat and drink independently and their food needed to be cut into bite-sized pieces. During our observation we noted this person was not supported for 20 minutes and their food was not cut as described in their care plan. We spoke with 3 staff members in relation to the level of support this person needed with eating and drinking to minimise the risk of choking. Two of these staff members told us the person could eat independently and the other staff member said a staff member should be with the person when eating. This demonstrates staff did not follow the person's care plan and some were unaware of the person's specific needs and risks. This placed the person at significant risk of harm.
- We discussed the concerns we had identified in relation to choking with the manager and they told us a

referral had been made in February 2023 for a Speech and Language Therapy (SaLT) assessment, this was still outstanding and had not been followed up. The manager also confirmed the person would now be assisted by staff.

- Where people had specific health conditions, including but not limited to, multiple sclerosis, diabetes, catheter care and constipation, there was not always an associated care plan or risk assessment detailing how to effectively manage these conditions, how the conditions affected each person and actions staff needed to take to keep them safe.
- Systems for staff to understand and handover key safety information about people were not robust. We found staff gave conflicting information about risks to people and how they were managed. We found information about risk management in care records was limited and not up to date. This meant people were at risk of receiving inappropriate care and treatment and were at increased risk of harm.

The failure to ensure people were provided with safe care and treatment was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We raised all the concerns highlighted above with a registered manager who confirmed actions would be taken to address these shortfalls.
- Following the inspection, a registered manager also confirmed all people at risk of choking had been referred for a SaLT assessment as per our request during the inspection.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding concerns were not always identified or addressed quickly enough to protect people from avoidable harm. For example, a person's health had significantly deteriorated because they did not receive the appropriate care and support. Whilst referrals had been made to assess their needs, those outstanding had not been robustly followed up to ensure a response. Staff had failed to follow guidance from health care professionals and written guidance for staff to follow had not been updated. The service failed to identify this neglect as a safeguarding concern. Visiting healthcare professionals made a safeguarding referral when they identified this neglect and found the person's health had deteriorated.
- The staff training matrix showed a high percentage of staff had not completed their annual refresher training in safeguarding. This meant the provider could not be assured staff had up to date knowledge about safeguarding to protect people from abuse. Staff we spoke with were able to tell us about the signs that could indicate abuse. Staff said they would report concerns to the manager, one staff member was not sure who they would contact if the concern was not acted on.
- At the time of the inspection a large-scale enquiry was being conducted by the local authority due to the volume of safeguarding concerns raised regarding people living at Radis Community Care - Maritime House. Following our inspection, we notified the local authority safeguarding team of concerns about people's care which we identified in this inspection. The provider did not have a robust system to identify and prevent the abuse of people using the service.

The failure to operate an effective system and processes to prevent the abuse of service users was a breach of Regulation 13(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not managed safely, and we were not assured people received their medicines as the prescriber intended. Planning for 'calls' to people using the service did not include medicines specific information to enable prioritisation. This is particularly important for when time specific medicines are prescribed.
- Of the medicines administration records (MARs) reviewed, all had gaps in the recording of medicines

administration, indicating doses had been missed. Although we identified some medicines had been recorded as being given on the daily notes of people, we could not be assured people had received their medicine as prescribed as administration information was not consistently recorded between administration records and daily notes. This put people at risk of duplication of medicines administration and / or poor management of their condition due to missed doses, for example poor symptom control where Parkinson's medicines had not been given.

- Where medicines were prescribed 'when required' (PRN), staff did not always have access to information to manage PRN medicines safely and effectively.
- Records were not fully completed following administration of PRN medicines, this included not recording the reason for administration, the time medicines were administered or if they were effective. Recording of this information helps ensure medicines requiring a specific interval between doses (such as paracetamol) are not administered too close together. This placed people at risk of overdose. Clear recording also allows the monitoring of a person's condition, highlighting if a review of their medicines may be appropriate.
- We were not assured that the communication and recording of medicines information between healthcare professionals and the service was effective. There was no process for staff to follow for the verification of medication changes when these had not been communicated by the prescriber. This put people at risk of avoidable harm.
- Some medicines prescribed could pose a wider risk to people, however this had not been considered. For example, anticoagulant medicines cause an increased risk of bleeding and paraffin-based emollients can be a fire risk. No specific care plans or risk assessments were in place in relation to these medicines.

This failure to ensure the safe management of people's medicines was a breach of Regulation 12(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- There were insufficient numbers of staff deployed to keep people safe and meet their needs in a timely way.
- Staff members told us due to staff shortages and the level of support people required care calls were rushed or shortened, which meant people did not consistently receive their planned care. A staff member told us, "Things get missed, like having to give a person a wash instead of a shower. On a Sunday you can have 6 extra calls so we are not doing the best we can because we are in such a hurry." Another staff member said, "We have the normal round and then 'add ons' (additional calls) which means you finish later and some staff rush calls." A relative said, "Sometimes the carers are scheduled for 45 minutes, but the books don't balance as they are signing out after 20 minutes." We reviewed the daily care records of 4 people over a 10-day period and found 3 of these people did not consistently receive care calls of the duration described in their support plans.
- A relative told us about mistakes made by staff and reflected this may be due to the pressure staff were under. This relative said, "There was an error made with medication in that [person] got it twice ending up with them getting a double dose" and, "Yesterday the carers put eye drops in [person's] eyes instead of [person they were prescribed for]." The relative added, "They are short staffed, and they really haven't got time to think. They are rushing a job through without proper thought."
- Staff, people, and relatives told us staff were under pressure from responding to call bells and supporting people with complex needs. A staff member said, "We can't keep up with the buzzing. 15-minute calls often take 30 minutes."
- The provider did not have a robust system in place to assess the levels of staff within the service to help identify if people's needs were met, and call bells responded to appropriately. Within the provider's annual quality audit, completed in July 2023, there is no reference to call bell monitoring, and it described staffing levels to be reviewed as and when required. There was no evidence this had been done.

- We asked a registered manager about how they monitored the duration and timing of care calls delivered. They told us daily records were audited to monitor care calls, but this had not been completed recently and no analysis was available. This meant we could not be assured people were receiving their planned care.

The failure to ensure sufficient numbers of staff were deployed to meet people's care and treatment needs was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At the time of our inspection staffing levels/deployment had already been identified as a concern by the local authority and the service was working with the local authority to address these concerns. We received some feedback staffing levels had recently improved due to the use of agency staff. Overall feedback from people and relatives was positive about the care they received from staff; however, this was mixed with concerns raised about length of calls, timing of calls and organisation of calls.
- While we acknowledge improvements were being made, we could not be assured these concerns would have been identified or acted on without input from the local authority or that these improvements will be embedded or sustained.
- Recruitment files had recently been audited by the provider's central office staff. Shortfalls had been found and these were followed up. This function had now been taken over by central office staff to ensure recruitment was safe and the relevant checks were completed. In the files we reviewed we found the provider was operating safe recruitment practices.

Preventing and controlling infection

- We were not assured the provider was supporting people living at the service to minimise the spread of infection. We found infection control procedures were not always followed by staff. For example, a person's risk assessment stated, 'soiled/wet incontinence pads are double bagged and disposed in a bathroom bin.' However, when we visited this person an unbagged incontinence pad was seen in an open topped bin in their bathroom.
- We observed the staff office contained an open topped bin with discarded, used personal protective equipment (PPE). Two relatives told us they had found discarded PPE gloves on their relative's furniture and used continence pads on the bathroom floor. This meant staff were not following safe practice to dispose of products in line with national guidance, which can increase the risk of spread of infection.
- Staff training records showed a high number of staff had not completed their annual refresher training in Infection prevention and control (IPC). This meant staff may not have the knowledge and skills to support people safely. Following the inspection, a registered manager confirmed staff training would be addressed and monitored for completion.
- The provider's policy on IPC was out of date and contained links to outdated guidance. This meant staff did not have up to date information to support their practice in IPC. Following the inspection, a registered manager sent us an updated policy.

The failure to effectively manage the risks associated with the prevention and control of infections was a breach of Regulation 12(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives told us staff did wear the appropriate PPE when providing personal care.

Learning lessons when things go wrong

- An incident reporting process was in place but was not consistently followed. We reviewed incident reports and found investigations had taken place. However, not all incidents had an incident form completed by staff at the time of the event to ensure the record was detailed and captured important

information. Incident reports help to identify the cause and support learning to prevent a reoccurrence.

- Complaint records were not fully completed to show learning had been captured from investigations and shared with staff.
- A system was not in place to monitor trends from incidents, such as falls. This enables the provider to identify factors which can be addressed to help prevent or minimise further falls.
- There was limited evidence to show that learning was being captured and disseminated when things went wrong. When issues were identified, remedial actions were not always in place or monitored to address improvements. This meant people continued to be at risk of inappropriate care and support. For example, a team meeting had been held to discuss medication errors, however this continued to be of concern at the following team meeting. We have outlined these shortfalls further in the well-led section of this report.

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.

This is the first inspection for this newly registered service. This key question has been rated 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 staff were skilled and competent in delivering care. The provider's training records showed that staff had not received adequate training in a timely way to equip them to do their roles, safely and effectively. We reviewed the providers mandatory training requirements of all care staff. There was a high percentage of non-completion of yearly refresher training in topics such as confidentiality and information handling (GDPR), safeguarding, medicines management, infection control, manual handling, and mental capacity.
- Staff did not complete training in specific health conditions although they supported people with these needs. This included Parkinson's, diabetes, end of life care, pressure care and catheter care. There was a lack of guidance to support staff when caring for people with these conditions which meant staff had neither guidance nor training to support the delivery of safe and effective care.
- We received mixed feedback about the skills and competency of care staff from people and relatives. A person said, "The carers look absolutely well trained, and they have a good cross-section of skills." However, comments from relatives included, "There are more issues happening with new carers", "The care standards over all are 6 to 7 out of 10", "In the ideal world I would like to see more care and attention to detail" and, "The consistency is lacking a bit from one carer to another in regard to communication and training. I think more thought and attention to detail is required."
- Staff records we reviewed showed a lack of supervision, annual appraisal, and spot checks to oversee their performance. The provider had a policy of quarterly supervision but there was no evidence this had been met.

The provider had failed to ensure staff received appropriate training, support, supervision and appraisal to enable them to carry out the requirements of their role and meet the needs of the people they supported. This placed people at risk of harm. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A registered manager told us all staff had been booked in for an appraisal and shared their intention to address shortfalls in staff training.
- Staff new to care completed the care certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sector. It is made up of the 15 minimum standards that should form part of a robust induction programme. Records showed most staff had completed this with some new starters in the process of completion. In addition, induction included a period of new staff shadowing experienced staff.

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

We checked whether the service was working within the principles of the MCA.

- People were not always supported to have maximum choice and control of their lives. There was a systemic lack of understanding in relation to the roles and responsibilities held by the provider and staff in relation to MCA. For example, the management team relied on external professionals to carry out assessments of people's capacity to consent. This failure to act in accordance with the requirements of the MCA and associated code of practice, placed people at risk of unnecessary delays in appropriate consent to care being sought.
- When concerns about people's ability to consent to care and treatment were identified, a mental capacity assessment was not carried out in line with the provider's policy. For example, a person receiving support with their medicines told us, "I don't know where they [medicines] are, I don't know if I've got tablets, they [staff] put them away from me." This person's support plan confirmed staff were to lock medicines away. A staff member confirmed the person declined their medicines and wouldn't know if they had or had not taken them. However, their support plan stated they had full capacity and were fully independent with their medicines. A mental capacity assessment had not been carried out to determine whether the person was able to consent to this arrangement or whether the arrangements were made in their best interests. Although we were satisfied the providers intentions were to keep the person safe, they had failed to follow the principles of the MCA and follow the best interest process.
- We found 2 other examples of people who, in the opinion of a registered manager and 2 staff, lacked the capacity to make decisions about their care. However, their support plans stated they had capacity and no assessment had been carried out to evaluate this. The MCA states people must be assumed to have capacity unless there is evidence that they lack capacity for particular decisions.
- Some people were provided with equipment which restricted their movements, for example bed rails. Decision specific mental capacity and best interest decisions for the use of bed rails had not been completed. A risk assessment for their use prompted the need for consent from either the person or their 'next of kin' yet there was no record of who had consented to their use. Staff told us this person may not have the capacity to consent. This meant this person's movements may have been unlawfully restricted.
- According to the provider's training policy, staff were to complete MCA training at 2 yearly intervals, the provider's training matrix showed some staff were not up to date with this training, but this was not identified on the matrix. Three out of 5 staff we spoke with were unable to tell us about how they used the principles of the MCA in their work with people or what these were.

The failure to assess people's capacity and record best interest decisions risked compromising people's rights. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

- People's eating and drinking needs were not always assessed to ensure they received safe care and treatment. Care plans did not always contain up to date information or guidance about what support was required. The support people needed was not always understood by staff. This is further reflected on within the safe section of the report.
- We found the service did not sufficiently monitor or manage the risks associated with poor hydration and nutrition for people who were reliant on support. One person had been identified as suffering from dehydration during a recent hospital stay. Their relative said, "Fluid monitoring is rubbish, it's hard to tell whether [person] has had a drink or not." We reviewed their fluid records which showed they received 1 or 2 drinks per day. There were no amounts recorded or target intake to show whether they had sufficient amounts of fluid intake. This was the same for other people we reviewed.
- Monitoring records to show what people had eaten, who were at risk of poor nutrition, were not completed consistently to enable effective evaluation. For example, we reviewed records for one person, who was cared for in bed and reliant on staff for food, which showed they had not received food every day. In addition, these records did not show the amount eaten and there was no evidence these records had been reviewed. This lack of information could result in the person not receiving the support required to maintain adequate nutrition and hydration.
- Staff were not consistently clear about the support people required with eating. For two people with a risk of choking staff gave conflicting answers about whether they should have staff assistance to eat. Their support plans did not include up to date guidance for staff on the assistance they required. This meant people could be at risk of not receiving the right support to prevent harm.

The failure to assess and monitor risks to a service user's concerning their nutritional and hydration needs, was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- We spoke to the manager about the concerns above and they showed us a new system of recording which was being implemented to improve these records and enable effective monitoring. This was being implemented at the time of our inspection. However, this system had not yet resulted in improvements.
- Where staff prepared meals for people positive feedback was received on how this was done. A person said, "The carers make nice food that I'm really satisfied with." Relatives' comments included, "I buy the food, but the carers prepare it and my relative is happy with the standards" and, "The carers prepare good food for her, but they also promote her independence by encouraging her to go to the café sometimes."
- Staff completed training in safe food handling and fluids and nutrition and records showed this was up to date.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's care records did not always include specific up to date care plans and risk assessments in relation to people's individual health needs. Guidance was not always available to staff to help them identify changes in people's health or actions staff should take should a concern arise, including when to involve other healthcare professionals.
- One person had been assessed by a healthcare professional and guidance was provided to staff in relation to appropriate management of their condition. This had not been followed consistently by staff and the person's health had deteriorated. For another person, guidance was not consistently followed in relation to their blood glucose testing to support the health professionals who managed their diabetes. This put them at risk of significant harm.
- We could not be assured, when health needs were identified by the staff and referrals had been made to external health care professionals, these were robustly followed up or escalated by the management team

to help ensure timely response. For example, a person had been waiting for a replacement wheelchair since November 2021, however this had not been resolved at the time of the inspection. The lack of suitable equipment had impacted negatively on the person's health.

- Additionally, although some referrals had been made to the healthcare professionals when people had difficulties swallowing, some of these were still outstanding and limited action had been taken to address this. This meant people remained at risk of harm.
- The manager told us most visiting healthcare professionals did not handover information about people's needs following visits and interventions. However, there was no process in place to ensure effective communication with these professionals. For example, we asked for the outcome of a referral to a falls team for a person, the manager told us "We don't know the outcome we haven't asked for it."

We recommend the provider seeks best practice guidance about joint working in health and social care and updates their practice accordingly.

- The provider had started to identify improvements in working with other agencies to promote positive outcomes for people as part of the improvement process with the local authority.
- Records did show that people received support from a variety of health care professionals including GPs community nurses, occupational therapists and the mental health team.

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

- Care and support did not always reflect current evidence-based guidance, standards and best practice. For example, the provider did not follow national guidance or use nationally recognised tools such as MUST (Malnutrition Universal Screening Tool) to assess the risk of malnutrition or a tool to assess risk of pressure ulcers. These tools help to ensure care is planned based on best practice to minimise risks to people.
- In addition, the provider had failed to act in accordance with the Mental Capacity Act 2005 to ensure people's legal rights were upheld. This is explained further in this section.
- In the care plans we reviewed we found people's needs were not consistently reviewed and care plans updated to reflect their changed needs. For example, a person had returned from a hospital stay in May 2023 and their care plan had not been changed to guide staff on their changed needs. For another person, their care needs had not been reviewed and updated although their needs had changed as they were coming to the end of their life. Three staff told us care plans did not always have up to date information. This meant staff did not have access to up-to-date guidance on people's needs and they were at risk of receiving inappropriate care.
- People were admitted to the service following a needs assessment from a local authority social worker. Their needs were presented at a panel and a member of the provider's management was present. A registered manager told us sufficient information was not always provided to ensure the service could meet the individual needs of people. As a result, there was not always enough staff with the required knowledge, skills, training, and competence when people moved into the service. This meant the service struggled to meet the expectations and needs of some people. A registered manager said they would be attending the panel more frequently to check the process supported appropriate placement. We are aware the local authority is working with the provider to address this.

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.

This is the first inspection for this newly registered service. This key question has been rated Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- We found staff we spoke with to be caring and kind and our observations of staff interactions with people confirmed this. However, some staff told us they felt the staffing levels could result in them not being able to provide people with the standard of care they required. They told us they were not able to sit and talk with people for any meaningful length of time due to pressure of work. A staff member told us about people who were lonely and said, "You can't give as much. Its more lack of quality time."
- We received mixed feedback from people and relatives about the caring nature of the staff, with the majority telling us the staff were kind and caring. People's comments included, "They [staff] are so gentle and caring when doing all my duties" and, "They are kind and compassionate and treat me with dignity." A relative told us, "The carers usually have a good personality and [person] is well respected and treated with dignity. As a relative I also get on well with them [staff]."
- We also received some feedback that staff could be 'rushed' or 'impatient' and that people did not always receive consistency of care due to staff changes. A person said, "There are some [staff] that are more respectful than others, I have to show them how to do everything and [staff] don't always listen."
- Arrangements to monitor the approach of staff were not consistently completed to enable the provider to be assured people were always well-treated. This included, staff spot checks, reviews of care and systems to gather feedback from people.
- Staff had completed training in equality, diversity, and inclusion and those we spoke with demonstrated an awareness of non-discriminatory practice. A person told us that when they asked for gender specific staff this had been provided.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- We could not be assured people were always fully involved in decisions about their care. For people who may lack the mental capacity to make decisions the process to determine this was not always followed. We have described this in the effective section of this report.
- A relative of a person who was living with dementia told us their relative would say 'yes' if asked a question. They said, "Staff need to give a choice, not just question yes or no. That doesn't always happen." This was also a concern for 2 other people. For another person who could not always communicate verbally, we asked them whether care staff knew what they needed and they indicated 'no' using a card. This person's care plan had not been recently reviewed.
- A staff member told us they used personal phones between staff to pass on information because handover information was limited, and records confirmed this. This represented a risk to people's privacy

under the General Data Protection Regulation (GDPR).

- Other people who were able to express their decisions told us staff respected these. People's care plans included information to support staff to promote people's independence. A person said, "The carers support improves my independence a lot, especially with washing."
- Staff completed training in dignity in care and those we spoke with knew how to provide respectful care for people.

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires improvement. This meant people's needs were not always met.

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

- People's care needs were not consistently reviewed, and people's care plans did not always reflect their needs and preferences. Some care plans we reviewed were out of date and did not sufficiently guide staff on people's current care and support needs. As we have described in the safe and effective questions of this report, we found examples that showed needs assessments and care plans did not always address people's needs and/or risks or consider their mental capacity. This meant people were at risk of inappropriate care and support.
- We received mixed feedback from people and relatives about their care plans. Some people were not aware of their care plan and others said their care plans were up to date and accurate. Some relatives thought care plans required review and others said they were involved and satisfied with the care plan in place.
- Most people who could tell us about their care said their care needs were met. However, for some people who were less able to give their feedback we found records were not consistently completed to show their needs and preferences were met. This included care with repositioning, food and fluids and health care monitoring. A person's preference as stated in their care plan for a bath had not been met for several months. Their relative told us, "More often than not [person] gets a body wash." Their relative told us it was unlikely the person would state their preference if asked.
- Staff told us information available to them was not always up to date and changes to people's needs were not communicated effectively. A staff member said, "Some calls should have information as agency staff only have the call time and no other information. A senior may write down things to do that would help. If we had phones as well as you could see what to do, I would like a list of tasks so then nothing would be missed – something could get missed it would help us." We reviewed a selection of team leader reports which are completed to handover information to staff. We found very limited information was recorded. We reviewed an agency worker worksheet which had no information other than call times.
- As described in the caring and effective questions in this report people were not always involved in decisions about their care.

The failure to provide appropriate care to meet the needs and reflect the preferences of people was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- We spoke to a registered manager about this who agreed care plan reviews were not up to date. They told us they planned to carry out reviews with people and involve the family or representatives of the person where they agreed for this.

End of life care and support

- At the time of our inspection the manager told us they were supporting a person who was at the end of their life. We reviewed this person's care records and found there was no end-of-life care plan in place for this person. This meant there was no detailed information for staff on how to meet this person's needs effectively while ensuring their end-of-life wishes were followed and respected.
- The person highlighted above, indicated to us their needs were not always met by carers and they would prefer to have the same carers at this time. We discussed this with the manager who told us they were unable to provide the same staff. Furthermore, one staff member we spoke to who provided support to this person told us they didn't know the person was at the end of their life. This person's relative told us their care was variable subject to which staff attended.
- Their care plan did not show their needs had been regularly re-assessed which is important during this time to ensure appropriate care is provided. The person was receiving support from healthcare providers.
- Although the provider's quality report stated end of life wishes were included in people's care plan, we did not find this extended beyond advance decisions to refuse treatment and DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) decisions.
- It is important to support people and their families or carers to explore and record their wishes about care at the end of their life, and to plan how they will be met so that they feel consulted, empowered, listened to, and valued.

The failure to provide appropriate care to meet the needs and reflect the preferences, including planning for and supporting people at the end of their life, was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. 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.

- A registered manager was aware of their responsibilities under the Accessible Information Standards. We discussed how people were supported with their communication needs. A registered manager told us about a person supported using picture cards and we saw these were available to use. They said resources to support people's communication needs would be discussed with social workers at the time of their referral.
- People's care plans contained some information to support staff in how to communicate with them according to their individual needs. However, we could not be assured these were always met by staff. We received some feedback from a relative their care plan was not followed in relation to their communication needs. For another person, whilst their care plan stated they had sensory loss of hearing and sight there was little guidance for staff as to how to meet their communication needs.

We recommend the provider consider current guidance on the accessible information standard and take action to update their practice accordingly.

Improving care quality in response to complaints or concerns

- Some people and relatives we spoke with told us they had made a complaint. Feedback was mostly positive, and concerns raised had been dealt with to the complainants' satisfaction. A person said, "I did make a complaint last week because I just wanted all female carers only which I get now, office staff were very apologetic".

- Records showed complaints were investigated and overseen by a registered manager. However, the complaints system was inconsistently managed and the provider's complaints policy was not always followed. There was little evidence of any learning applied to practice within the service following a complaint. Not all outcomes of complaints were available in the records or actions checked for completion. There was no clear account of learning from complaints and learning had not been captured on the relevant records.
- A registered manager told us they planned to hold a complaints and disciplinary training session with the manager to clarify the process from start to finish. This is important to show people's feedback and experiences are used to improve the service and prevent a re-occurrence.

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

- As part of their planned care some people received support to access and engage in activities. For example, a person told us about attending archery with the support of a carer.
- Activities were available within the building which people could join if they wanted to. These included visiting support to access voluntary work, seated exercise sessions, and a 'dungeons and dragons' game session. Other regular events included bingo, games on a Sunday, quizzes, arts and crafts on Saturday and coffee morning on Monday. The manager told us a themed party was held every few months.

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.

This is the first inspection for this newly registered service. This key question has been rated 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.

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

- Quality assurance arrangements were not always applied consistently or were ineffective.
- There was a system of auditing however, these were not up to date and had failed to identify some of the concerns we found during the inspection. For example, audits of people's medication records to support the safe management of people's medication had not been completed since April 2023. Where audits had been undertaken previously, actions had not always been recorded, assigned, dated, tracked, or followed up to ensure the effectiveness of change. We found the management of people's medicines was not safe and this is explained in the safe question of this report.
- An audit carried out in February 2023 about staff supervision, training and support did not show actions had been completed. This audit had not been checked for completion. A further audit also referred to action required in respect of staff training, and we found these actions were still outstanding during our inspection.
- The provider's auditing of people's needs assessment, care plans, risk assessment and reviews was not effective. Audits looked at small samples of people's records and had failed to identify the shortfalls in the records we reviewed. Some of the records we reviewed had not been updated since 2021 even though people's needs had changed; therefore, up to date guidance was not available to staff. Likewise, an audit on 15 May 2023 on mental capacity looked at 3 people's records all of whom had mental capacity. The audit did not look at the records of people for whom staff had concerns about their mental capacity and was therefore not effective in identifying the shortfalls we found.
- We found concerns in the daily monitoring records of care delivered which were not completed in line with people's needs. There was no evidence these had been audited recently although the provider's compliance audit stated this should be weekly. The finding of the providers audit was, 'Back log of diary audits stored on top of cabinets' with an action to 'complete in a timely manner.' Therefore, the provider had failed to operate an effective system to monitor the care delivered or complete any robust improvement action. This meant people were at risk of not receiving planned care because the provider had failed to assure themselves this was happening.
- We asked a registered manager whether there had been a service quality improvement action plan in place prior to the local authority raising concerns with the service. They told us this had not been in place, but one had been developed based on the concerns received. This meant the provider had relied on concerns being identified by the local authority. The provider had failed to operate an effective system to identify concerns about the quality and safety of the service.
- An office team meeting was held on 29 March 2023 with team leaders. The minutes showed many of the concerns raised in this inspection report were discussed. However, we continued to find these concerns

during our inspection and so these had not been addressed in an effective or timely way.

- Processes to monitor and support the quality of care people received had not been managed effectively. This included staff supervision, staff training and spot checks of staff delivering care. This meant the provider had failed to operate an effective system to monitor the quality of care delivered.
- Records related to people's care and support needs were not consistently completed, up to date or accurately reflective of people's needs. We have described this further in the safe and effective questions of this report.
- The provider's policies to guide staff on complaints and the mental capacity act were not followed. The Infection Control policy given to us during the inspection was out of date. We received an updated version from a registered manager, but it was not in use at the service. This meant information to guide staff in best practice, standards and the law was not effectively implemented.

The failure to ensure the quality and safety of the services is appropriately assessed, monitored and improved, and the failure to maintain accurate, complete and contemporaneous records in respect of each service user placed them at risk of harm. This was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- New quality monitoring and call alarm forms were being put into place to check on care plans, risk assessments and medication.
- The service had two registered managers both of whom had other responsibilities within the provider's company. A manager was in post who was applying to become the registered manager and was responsible for the day-to-day management of the service. Concerns about the quality and safety of the service had led the local authority to issue a remediation notice. As a result, the registered managers were spending more time at the service to achieve improvements which were identified in a service quality and development plan.

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

- We received positive feedback from people and relatives about the leadership of the service. People and relatives said the manager was approachable and helpful and they had confidence in her leadership. People's comments included, "The relationship with the management of the house is brilliant. [Manager] can be contacted at any time, she is lovely and very approachable. She will go out of her way to help; she is a star!" Most Staff said they thought the manager was approachable and listened to them. A staff member said, "The manager is fantastic. [Manager's name] is excellent. She knows the residents' needs well."
- However, we found there was lack of consistency in how well the service was managed and led. We received mixed feedback from staff about leadership and culture of the service. Staff comments included, "Staff aren't listened to, and management don't always respect us. We don't get the staff as set out in the rota and they keep loading extra calls. I don't feel like there is much communication with anyone – there used to be a board in the staff room but this is not used you hear things from other carers like if someone is in hospital. I went to a call, and I hadn't been told." We were told staff used their own private WhatsApp group to let each other know about people's changed needs. We spoke to a registered manager about this who was unaware this was happening.
- Asked if they would recommend the service to a friend or family member one staff member said, "I wouldn't have family here as I can see the stress the carers are under." Another said they would recommend the service and a third said "No, I like the people, but we can't provide the care they need."
- Other concerns raised by staff included staff taking 'shortcuts' with people's care and newer staff not being confident or competent which was not being picked up by managers. As reported in the safe question, we did find evidence that calls were not always for the planned duration and staff reported feeling rushed at

times. Staff training required updating and supervision and spot checks were not consistently completed. This meant the provider could not be assured the culture supported the delivery of high-quality person-centred care.

- A registered manager told us they were introducing vision and values training for staff, and these would be discussed in the staff meetings. In addition, the registered manager shared their plans to update staff training and supervision.

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

- Staff were consulted as part of the quality assurance audit carried out by the provider's quality and compliance department on 04 July 2023. Asked if there was clear communication between staff and managers regarding service users and rotas, staff stated communication could be better. Others stated some of the office team are understanding although others are not. There was no action plan arising from this feedback.

- Another stakeholder survey carried out in March 2023 included staff amongst other stakeholders. However, feedback was not described by stakeholder group which would assist the provider to identify improvement areas. Thirty percent of respondents (nine) had expressed dissatisfaction. Areas for improvement included communication and information for service users.

- Staff feedback we received included comments about poor communication processes which we have described in the culture section of this key question.

- A stakeholder satisfaction survey had been sent out in March 2023. This included service users, families, and professionals. The survey received 5 responses. Responses were mostly positive with either 'very satisfied' or 'satisfied' with the service provided. Respondents had reported on what is being done well and what could be done better. Suggestions for improvements included more staff needed, handwritten notes not always legible and bleach required in toilets. Positive comments focused on the caring, polite, and friendly attitude of staff. Actions to address areas where improvements were identified were not included in the service's quality and development plan.

- Recent minutes from a staff team meeting (06 July 2023) showed staff were given information about improvements required and new ways of working. Lessons learnt from medication errors were discussed and staff were asked how they would identify some common health conditions. The previous staff meeting on the 22 May 2023 discussed the number of medication errors and reasons for this. These concerns remained ongoing and had not been addressed or noted to have improved by the meeting in July.

- Tenants' meetings were held quarterly facilitated by the provider. A registered manager told us these were not well attended with one person attending the last the meeting and minutes were not available.

- A registered manager told us they held quality reviews with people to gather feedback about the service. However, these were not consistently evident in the records we reviewed. It was not clear how the provider used feedback from stakeholders to evaluate and make improvements to the service.

The failure to seek and act on the feedback from relevant persons and others on the service provided was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- A registered manager told us a survey had been sent out to all people using the service and quality reviews were planned to be carried out.

- We discussed how staff with protected characteristics under the Equality Act were supported. A registered manager gave us examples of this related to religion or belief, gender reassignment and sexual orientation. Events were held at the service to promote awareness of diversity such as sharing food and experiences from different cultures.

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

- A registered manager described their responsibilities under the duty of candour regulations. Relevant incidents had been responded to under the duty of candour requirements.

Working in partnership with others

- The service was working with the local authority and other professionals including healthcare, pharmacist, social workers, safeguarding and commissioners to make improvements.

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
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not being met The provider had failed to provide appropriate care to meet the needs and reflect the preferences of people supported. Regulation 9(1)

The enforcement action we took:

We have imposed a condition on the providers registration

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent How the regulation was not being met The provider had failed to ensure care and treatment was provided with the consent of the relevant person Regulation 11(1)

The enforcement action we took:

We have imposed a condition on the providers registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met The provider had failed to ensure people were provided with safe care and treatment. The provider had failed to manage medicines safely The provider had failed to effectively manage the risks associated with the prevention and control of infection The provider had failed to ensure risks associated with nutrition and hydration were managed safely

The enforcement action we took:

We have imposed conditions on the providers registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met The provider had failed to operate effective systems to prevent the abuse of service users Regulation 13(1)

The enforcement action we took:

We have imposed a condition on the providers registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met The provider had failed to ensure the quality and safety of the service was appropriately assessed, monitored and improved, The provider had failed to maintain accurate, complete and contemporaneous records in respect of each service user. The provider had failed to seek and act on feedback from relevant persons on the service provided Regulation 17(1)

The enforcement action we took:

We imposed a condition on the providers registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met The provider had failed to ensure sufficient numbers of staff were deployed to meet people's needs. The provider had failed to ensure staff received appropriate training, support supervision and appraisal necessary to meet the needs of the people they supported. Regulation 18(1)(2)

The enforcement action we took:

We have imposed a condition on the providers registration