

# Achieve Together Limited

## 57 Bury Road

### Inspection report

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### Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	Inadequate ●
Is the service effective?	Requires Improvement ●
Is the service caring?	Requires Improvement ●
Is the service responsive?	Requires Improvement ●
Is the service well-led?	Inadequate ●

# Summary of findings

## Overall summary

### About the service

57 Bury Road is a residential care home providing accommodation and personal and care to five people at the time of our inspection. The service predominantly supports people living with a learning disability and/or autism and can support up to six people.

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

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

The model of care and setting did not fully maximise people's choice, control and independence. For example, people lived in an environment where safety issues had been identified and was not clean or homely. The registered manager told us following the inspection, the refurbishment of people's bedrooms had begun. The environment did not meet people's sensory needs. However, people had privacy for themselves and their visitors and the service was located so people could participate in the local community.

Ethos, values, attitudes and behaviours of leaders and care staff did not fully ensure people using services led confident, inclusive and empowered lives. It was not clear how people had been empowered to have as much choice and control over their care as possible. Staff were motivated to do the best they could for people.

The service was not always maximising people's choices, control or independence. Care was not always person-centred. For example, while staff knew people well and were caring in their approach and treated them with kindness and respect, care plans were not always person centred. We have made a recommendation about this.

The provider had not established an effective system to ensure people were protected from the risk of abuse. Risks to people's health and wellbeing had not been monitored or mitigated effectively.

People were at risk of harm because staff did not always have the information they needed to support people safely. Medicines were not always managed safely. The provider had not ensured there were enough numbers of competent and skilled staff to support people safely.

People did not receive a service that provided them with safe, effective, compassionate and high-quality

care. The provider had not established an effective system to ensure people were protected from the risk of abuse. A lack of timely action by leaders to ensure the service was well staffed and safeguarding incidents were responded to meant people did not lead inclusive or empowered lives. Although staff had a good understanding of safeguarding the registered manager had not always reported safeguarding concerns to the local authority and CQC.

Leadership was poor, and the service was not well-led. Governance systems were ineffective and did not identify the risks to the health, safety and well-being of people or actions for continuous improvements.

The provider did not have enough oversight of the service to ensure that it was being managed safely and that quality was maintained. Quality assurance processes had not identified all of the concerns in the service and where they had, sufficient improvement had not taken place. Records were not always complete. People and stakeholders were not always given the opportunity to feedback about care or the wider service. Staff morale was low. This meant people did not always receive high-quality care.

People were supported with equality and diversity however, this impacted on other people using the service.

People were not always given the opportunity to feedback about care or the wider service.

People had access to various activities and were involved in the preparation of a weekly 'fun day.'

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Rating at last inspection

This service was registered with us on 26 January 2021 and this is the first inspection.

The last rating for the service under the previous provider was Good (published on 20 August 2018).

#### Why we inspected

The inspection was prompted in part due to concerns received about document recording, medicines, restrictive practices, failure to notify the local authority of incidents, inappropriate management of incidents. A decision was made for us to inspect and examine those risks.

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.

You can see what action we have asked the provider to take at the end of this full report.

The provider had responded to some of our concerns immediately and told us they would put plans in place to make improvements for the other concerns.

The overall rating for the service is Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 57 Bury Road on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to

hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, medicines management, infection prevention and control, safeguarding, staffing and recruitment, following the mental capacity act, environment, duty of candour, failure to report incidents of concern and quality assurance at this inspection.

#### Follow up

The overall rating for this service is 'Inadequate' and the service is 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?

**Requires Improvement** ●

The service was not always 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.

# 57 Bury Road

## 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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

#### Inspection team

This inspection was carried out by two inspectors.

#### Service and service type

57 Bury Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

#### 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 and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this

report. We used all of this information to plan our inspection.

#### During the inspection

We carried out observations of people's experiences throughout the inspection. We spoke to four relatives about their experience of the care provided. We spoke with four members of staff including the regional manager, registered manager and care workers.

We reviewed a range of records. This included three people's care records and five people's medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

#### After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We looked at three staff files in relation to recruitment and staff supervision. We reviewed policies and a variety of documents the registered manager sent to us. We spoke with a further five members.

# 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 for this newly registered service. This key question has been rated inadequate.

### Assessing risk, safety monitoring and management

- Risks to people were not always managed safely. Care plans and risk assessments lacked enough detail to ensure people were supported safely. For example, one person had a medical condition which posed significant risks to them and required clear guidance for staff to follow. Their support plan did not detail what staff should do if they experienced an episode lasting longer than usual.
- We asked staff at what point should they seek medical assistance, episodes usually lasted up to two minutes, one staff member said they would contact 999 if it lasted more than three minutes, another staff member told us they would call 999 if it lasted longer than five minutes. This meant staff did not know at what point medical assistance should be sought which could put this person at serious risk of harm.
- People and staff were harmed on a regular basis due to incidents caused by people's behaviours that challenged themselves and others. This meant the management of these behaviours were not effective, this put people at risk of harm.
- The registered manager told us staff received a debrief following an incident. Staff told us they did not find these effective. We reviewed a debrief document which recorded a person's behaviour had become heightened for a period of half an hour and due to this had attempted to harm staff. The debrief document did not clearly identify the triggers that made the person upset nor did it provide a clear audit trail to demonstrate the person completing the debrief had the skills and competencies to do this to reduce the risk of a reoccurrence, this placed this person and others at risk of harm.

The failure to assess and do all that is reasonably practicable to mitigate risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Systems and processes to safeguard people from the risk of abuse

- The provider did not always have effective systems and processes in place to safeguard people from the risk of abuse.
- Safeguarding incidents were not always reported to the local authority. For example, we saw records where people had unexplained bruises, although they had been reported to the manager no further investigation had been taken place. The failure to recognise possible abuse, and the lack of reporting, and investigation into unexplained injuries meaning people were at risk of recurring harm because the cause of the injuries had not been established.
- We spoke to the manager about this who told us they would make retrospective reports and would review their system to ensure any such incident would be reported to the appropriate people going forward and investigated.
- We were not assured that all incidents which could constitute a safeguarding alert or concern were being identified by the registered manager. This was because the system to review and monitor incidents was not effective.



- Most family members thought their relative was safe from the risk of abuse at 57 Bury Road however, one relative told us they didn't think their relative was totally safe and was concerned they were not always kept informed about the details of incidents which had occurred.

The failure to safeguard people from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Staff we spoke with had a good understanding of safeguarding and all said they would report any concerns to their manager. Staff were aware they could report to CQC and told us there was a file with contact details of relevant authorities.

#### Staffing and recruitment

- The provider had tried to ensure there were enough competent and skilled staff available to support people safely. Agency staff were being heavily relied on during the week of the inspection due to several staff members calling in sick. The registered manager told us they always met their minimum safe staffing levels of three staff on duty during the day shifts and rotas confirmed this. However, people were funded to have four staff on shift, this meant people were not receiving all the hours of support assessed as required by people to meet their needs.
- Staff did not feel they could always provide people with the care they required in line with their personal preferences and choices. A staff member said, "If there are enough staff on shift, yes, if not then no. The staff want to do their best but because of the staffing problem its difficult." Another staff member told us with less staff there is, "More pressure and demands so we are less able to give personalised care."
- Regular staff working during the inspection were observed to be very busy. Some agency staff appeared uninterested. For example, we observed one agency staff member sitting on a table looking at their mobile phone for a period of over 10 minutes.
- Relatives told us there were not enough staff, their comments included, "Never no, [person] is supposed to have [more than one staff member] to himself at times, there are never enough staff," and, "No, all the time, whenever I phone staff have been on 10 days and 14 days in a row, it always seems to be like that." Another relative told us it was difficult to say because they hadn't been in for a long time.
- Staff comments included, "We are struggling with staff at the minute...Staffing levels have never been this bad," and, "[Staffing] is a big issue for a while now, sometimes only two or three staff on, staff are complaining. We recently started using agency staff, agency staff don't know anything about the people we support which can cause a problem with the time we have to provide care to people, different agency every day does not help continuity for people."
- People were supported to go out and participate in activities although this was dependant on having the right amount of trained staff on duty. One relative told us they had been asked not to visit due to the lack of staff. Retuning from visiting could result in behaviours which would be difficult for staff to manage if they did not have a full complement of staff on duty. We spoke to the registered manager who told us a lot of staff had called in sick this week and they didn't normally use agency staff to the extent it was being used during the inspection.

The failure to have sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The recruitment of staff was safe. Appropriate recruitment practices had been carried out. This included completing checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.
- The registered manager told us they were continuing to recruit people and had one regular agency staff

member who was transferring to be employed by Achieve Together.

### Using medicines safely

- We could not be assured medicines were always managed safely. For example, one person was prescribed a medicine to help with their breathing. This medicine was kept in a lockable tin attached to their bedroom wall. We observed this was not locked during the inspection. The registered manager told us it should be locked. We also observed creams unlocked in people's bedrooms. There was no opening date on the creams which meant staff would not know when to dispose of the cream according to the manufacturer's instructions. This meant the cream could become ineffective.
- People were prescribed 'as required' (PRN) medicines and there were PRN protocols in place however, these did not always contain enough information to guide staff how to administer them safely. For example, one person was prescribed an inhaler, the PRN protocol guided staff to administer one or two puffs when required. There was no guidance about when to administer one puff and when to administer two puffs. The protocol guided staff to seek medical attention if symptoms persisted but did not specify how long they needed to wait before seeking medical attention.
- One person was prescribed PRN paracetamol one or two to be taken four times a day when required however, their PRN protocol stated, '500mg (take 1 tablet up to four times a day.)' This was different to their prescription. This meant the person may not receive appropriate pain relief. The PRN protocol advised staff to contact the GP if symptoms persist for more than a week. This meant staff were not guided to seek medical support in a timely manner which could lead to prolonged pain for the person.
- One person was prescribed medication to help with their anxiety and increased behaviour, there were two PRN protocols written for this medication both with the same date. One was detailed, the other was confusing and did not give clear guidance when to administer the medicine. We spoke to the deputy manager about this who told us both were put in place because the detailed one had not yet been signed by a GP but had been written by the positive behaviour support team. After discussion the deputy manager removed the PRN protocol which was confusing. Having two protocols which do not provide the same information is confusing for staff and could lead to mistakes in the administration of this medicine.

We found no evidence people had been harmed however, systems and processes were either not in place or not robust enough to demonstrate safe medicines management. The failure to ensure safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Preventing and controlling infection

- We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. The premises were not hygienic. For example, bedrooms and bathrooms were unclean. We saw several cobwebs in people's bedrooms and bathrooms and some bathmats had mould on them. One person's toothbrush was old and splayed.
- There were no clear definitions of specific roles and responsibilities for cleaning and no clear, agreed, and available cleaning routines as specifically required in the providers infection prevention and control policy. The cleaning schedule which was in place was ineffective.
- Quality assurance audits relating to infection control were not robust. Where concerns had been identified in these audits' actions had not been taken due to the provider waiting for a refurbishment. For example, the infection prevention and control audits carried out in April 2022 identified the auditor was not confident there were no leaks, no evidence of water damage, no mould or smell of mould and that all bathrooms were adequately ventilated. The action needed to address this stated, "Awaiting refurb." The refurbishments were not planned until July 2022. This meant people were living in an environment which could put them at risk of harm and no immediate action was being taken.

- Fridge temperatures were taken daily by staff; however, fridge temperatures were consistently recorded at over eight degrees Celsius (8°C) The optimum temperature for a fridge is 5°C but must not exceed 8°C. This is because temperatures between 8°C and 63°C is known as the "Danger Zone" and bacteria can grow and multiply. This meant people were at risk of eating foods which may harm them.
- The infection prevention and control and food safety audit which took place on 31 May 2022 was ticked to say fridge temperatures were within the correct range. Staff consistently recorded that no remedial action had been taken. This meant staff and the registered manager had not picked up on fridge temperatures being in the danger zone and continued to provide potentially unsafe food and drinks to people.
- The refurbishment of bedrooms was brought forward following the inspection and started in June 2022, however, we asked when the refurbishment of all other areas would take place, the regional manager told us it would be dependent on a review of finances due to the refurbishments costing a significant amount. This meant although people's bedrooms had been started on there was no timescale for the communal areas of the home.

The failure to ensure the correct management of infection control risks, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- On the second day of inspection, the registered manager had taken action to improve the cleanliness within the service. They shared the new cleaning schedules they planned to implement to ensure cleanliness of the service was maintained.
- Following the inspection, the registered manager told us they had ordered a new fridge.
- We observed staff wearing the appropriate PPE and the provider was testing staff in line with the current guidance.
- The provider was facilitating visits for people living in the home in accordance with the current guidance.

#### Learning lessons when things go wrong

- The provider did not have a robust system in place to monitor accidents and incidents, or to identify any patterns or trends. Although we saw evidence incidents and accidents were recorded there was insufficient evidence following incidents and accidents that investigations had taken place. There was no effective analysis of why these incidents may have occurred or measures had been implemented to reduce the likelihood of this happening again.

# 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 requires improvement.

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

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

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

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

- We were not assured the provider was working in line with the principles of the mental capacity act. Where people lacked capacity to consent, mental capacity assessments had not always been completed for specific decisions. These related specifically to money management. For example, one person had a mental capacity assessment and best interest decision for Achieve Together (the provider) to manage their day to day finances. However, care plans relating to this person identified two different specific decisions around finances which did not have a mental capacity assessment or best interest meeting. Under the Act, mental capacity is both 'decision specific' and 'time specific'. This means that the principles of the Act must be applied each time that a decision needs to be made.
- Where the mental capacity assessments were in place these did not contain enough detail. For example, under the heading 'What steps were taken to maximise the person's ability to make the decision? Including support with any primary language barriers or communication needs' there were no comments. There was no evidence any attempt was made to consult with the person. This was typical of all the mental capacity assessments seen.
- Although there was a best interest decision form in place this did not evidence this particular decision had been discussed with the person. The form records, 'All those close to [Person] feel this is the best decision for [person]' however, does not specify who all those people are. Although parents were consulted the form had not been signed and the decision maker had not been identified. This was typical of all the best interest decisions which have been documented. This lack of recording meant we could not be assured, decisions which could impact on people's quality of life, were being made in people's best interest.

Providing care and treatment without the consent of the person or in their best interests following mental capacity legislation was a breach of regulation 11 of the Health and Social Care Act 2008.

- Following the inspection, the registered manager told us they would ensure mental capacity assessments and best interest decisions would be in place going forward.

Adapting service, design, decoration to meet people's needs

- We found the home, except for the kitchen, was very poorly maintained, so could not be effectively cleaned.
- For example, areas throughout the home were in a poor state of repair. There were holes in the walls, peeling paint in several rooms, including bedrooms, bathrooms and communal areas. There were stains on the walls and ceilings and furniture with missing drawer handles.
- There were stains on bedding, mattresses and flooring, cracks in door frames and window frames and paint on walls in people's bedrooms had large areas of mismatching colours.
- People's bathrooms required new grouting and sealing; staff were unable to clean effectively due to poorly maintained facilities.
- Living in an environment as described as above, could have a negative impact on people's emotional, psychological and physical health.

The failure to keep premises clean and properly maintained was a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- The registered manager told us there were plans in place to address these issues and a refurbishment programme was due to start in July 2022. This had been delayed due to COVID.
- Following the inspection, the registered manager told us the refurbishment programme had started, people's bedrooms were the first rooms to be started on.
- People had been involved in decisions about the planned refurbishments. Mood boards had been completed with each person to establish their preferences for colour and design.

Staff support: induction, training, skills and experience

- We were not assured staff always received the training they required. A variety of training including, Mental Capacity Act and Deprivation of Liberty Safeguards (MCA and DoLS), fire safety and safeguarding was available however, staff were not always up to date with their training. Approximately half of the staff team had not completed basic life support training. This is important due to the high risk of injuries occurring for staff and people. Not all staff had completed MCA and DoLS training or equality and diversity training. The registered manager was out of date for equality and diversity training and was out of date for their safeguarding refresher training. This meant staff were not always sufficiently trained to meet the needs of the people they supported, and improvements were required in these areas.
- Staff received regular supervisions in line with the providers policy however, not all staff found this to be a useful exercise. One staff member told us, "There is generally, a problem with management, I want to learn more but the opportunity to grow has not been given." Another staff member told us, "The deputy manager listens the manager doesn't."

We recommend the provider considers current guidance on training and support standards for care workers and updates their practice accordingly.

- Staff had completed an induction which included the completion of the Care Certificate where required. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours

expected of staff working in the care sector.

- People's relatives told us staff were skilled and experienced. All relatives told us they thought staff were trained and did a good job. Their comments included, "On the whole they [staff] do a fantastic job, the odd one or two don't always," and, "Some [staff] have been there a very long time and they have a really good rapport with [person]." Another relative said, "I think they do [a good job]; they are restricted by institutionalisation."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before they moved into the home. Once this information was gathered, it was used to develop people's support plans and risk assessments with the support of people and their relatives. However, care plans and risk assessments were not regularly reviewed and updated when people's needs changed.
- Although some people had accessed GP's, dentists and opticians we found one person had not seen a dentist for a prolonged period. We spoke to the registered manager about this, they were not aware this person had not had a dentist appointment. The registered manager immediately phoned the dentist to arrange an appointment for this person.

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

- People had fluid charts in place however, the daily target for fluid intake was not completed. Care plans identified one person was on a restricted fluid plan and one person needed to be encouraged to drink fluids. Daily fluids given to people were not totalled at the end of the day. This meant it was difficult for staff to assess if each person had received the appropriate amount of fluids.
- People's dietary needs were met. People were provided with a balanced diet and fluids. The menu was planned using pictures and food items, each person choosing a meal to have during the week.
- People's relatives were positive about the food on offer. One relative told us, "The food is fine, I have seen what they have, [person] gets choices if they don't like what is on the menu, they will do them something else."
- We observed the lunchtime experience and found people enjoyed their meals and were supported in a positive and appropriate way.
- The staff were aware of people's speech and language therapy (SaLT) guidelines, likes, dislikes and preferences however, not all staff knew why SaLT guidelines were in place. Whilst this did not have an impact on people because staff knew what foods they could and couldn't have, it is important staff know about and understand guidance to support people's needs to ensure they are offered the right support and to reduce the risk of harm.

# 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.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- We were not assured people were always treated equally. One person could not eat pork due to their religious beliefs and this was supported. However, the registered manager told us the other people living in the service enjoyed roast pork every three weeks when this person goes home. They also told us people don't seem to mind having chicken-based sausages and turkey bacon.
- Following the inspection, the registered manager told us other people do have pork products available when they want it. However, staff told us pork was not available for people. Staff comments included, "[Person] can't have pork; we have pork once every three weeks when they go home. We give them [people] turkey sausages. We get turkey bacon for everyone. They have quite a lot of chicken and lamb." Another staff member told us, "No pork kept in the house... We only keep turkey bacon or chicken sausages. If people wanted a fry up or a bacon sandwich, they wouldn't be able to have one as that food is not kept in the house." We couldn't be assured the provider was meeting the needs of all people. Meeting the needs of one person impacted on other people.
- There was a lack of evidence people who were not able to express an opinion were always given choice and MCA decision making did not support that people were involved in decisions about their care. There was a risk of people's needs not being met because they were not given every opportunity to communicate them.

We recommend the provider seeks best practice guidance on how to meet the needs of all people living at 57 Bury Road and updates their practice accordingly.

- People's relatives told us their family members were treated with kindness and were positive about the staff's caring attitude.
- We observed staff interactions with people which showed people were treated with kindness, compassion, dignity and respect. Staff knew people well and understood their likes, dislikes and preferences.
- The registered manager and staff told us they aimed to ensure people's equality, diversity and human rights needs were supported and respected. People were asked questions about protected characteristics during the initial assessment stage. Documents also detailed how people identified in reference to their gender.
- Relatives confirmed they had been asked about people's preferences where they were unable to express

their views. One relative said, "Yes, they say they do involve me and [person] in decision making." Another relative told us, "Yes, definitely they do. [Involve family and the person in decision making.]"

- Staff understood people's rights to make some day to day choices. We heard people being consulted throughout the inspection about where they wished to go.
- Family members were welcomed at any time. One relative said, "We are always warmly welcomed."
- Most family members told us staff ensured they, and others who were important to the person, were kept updated with any changes to the person's care or health needs.

Respecting and promoting people's privacy, dignity and independence

- All of the people's relatives we spoke to told us staff respected people's privacy and dignity.
- Staff told us how they promoted people's independence and we observed this throughout the inspection.
- We asked staff how they promoted people's privacy and dignity, their comments included, "I always talk to people, make sure the doors are closed, make sure they look nice and clean and tidy. I make sure curtains are closed [when supporting with personal care]."
- Care files and confidential information about people was stored securely and only accessible by authorised staff when needed. This demonstrated people's confidential information had been stored appropriately in accordance with legislation.



# 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.

### Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The registered manager had a folder which had various easy read documentation in it however, we asked staff how this was shared with people, we were told it wasn't shared with people because they wouldn't understand it. This meant although easy read documentation was available this had not been used in a meaningful way to communicate important things with people, for example, how to complain about the service. The registered manager told us this was something they needed to work on.
- One person had a communication board in their bedroom and one in the 'quiet room' which used picture symbols however, we did not see these being used and the symbol remained unchanged throughout our inspection site visits. This meant although communication aids were in place, they were not being effectively utilised. The registered manager told us the communication board is usually used however, four staff members had called in sick this week and agency staff were not familiar with the people's routines.

We recommend the provider seeks guidance and best practice information how to communicate effectively with people and update their practice accordingly.

- Some staff had a good understanding of how to communicate with people and we observed some meaningful interactions during the inspection.
- The home had a set of food photographs to help people make menu choices.

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

- Care plans were not always personalised, and some contained other people's names in them. One person was prescribed eye drops, there was no guidance for staff about how the person preferred to have these eye drops administered. This meant staff could be administering this medication in different way and the persons wishes may not have been considered.
- People's needs were assessed prior to them moving to live at the home. Information from the initial assessments was used to develop care plans however, these were not always reviewed and revised as people's needs changed. Records of care provided confirmed people were generally being supported in line with the information in their individual care plans.
- Staff worked together well to deliver timely and effective care to people. They received a verbal handover between each shift. This helped inform staff of any changes in people's needs.

- People were encouraged to make their own decisions and choices where possible. For example, what time they liked to get up, when they wanted their lunch and where they wanted to spend their time. This was observed throughout the inspection.
- Staff were generally knowledgeable about people's preferences and care needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People who had relatives saw them on a regular basis, one person who did not have relatives had two advocates who saw them on a regular basis.
- People were engaged with staff throughout the inspection. Every week the service had a theme. The theme for the week of the inspection was festivals to coincide with the Isle of Wight Festival. People were encouraged to make decorations and bake to celebrate each week's theme on 'Sunday Funday' We observed people taking part in the activities and celebrating on Sunday with festival music and decorations made during the week.

Improving care quality in response to complaints or concerns

- The provider had a policy and arrangements in place to deal with complaints. They provided information on the action people could take if they were not satisfied with the service being provided.
- We looked in the complaints folder, there were no complaints recorded. We spoke to the registered manager about this who emailed us a complaint and action taken. It was documented the complaint was investigated and discussed with the complainant. However, written confirmation of the actions taken to address the matters detailed in the complaint did not take place in line with the providers complaints and concerns policy. We spoke to the complainant about this who told us, "My concerns were acted on and resolved properly."
- We asked relatives if they had ever made a complaint and if it was dealt with appropriately. One relative told us, "I nearly did but don't know who to go to. Not had complaints policy or document." They also told us, "Yes they, [registered manager and staff], are willing to listen but don't always take on board what you are saying. Another relative told us, "No complaint, yes, I would know how to. I think the registered manager would respond appropriately, she always gets back or leaves a message."
- Following the inspection, the registered manager told us they had found a template for recording and monitoring concerns which was set out in a much better and more detailed way. They planned to start using this template immediately.

End of life care and support

- At the time of the inspection end of life care has not been discussed with people and their relatives due to the service supporting mostly younger adults.

# 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.

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

- Leadership arrangements did not ensure the safety and quality of the service. The provider had failed to ensure there was adequate oversight of the service. Quality assurance systems and processes did not identify, or address issues found at inspection. We found multiple breaches of regulation.
- Systems and processes were not always operated effectively to ensure the service was safe and people were receiving high-quality care. This led to breaches of regulation and placed people at risk of harm as outlined in the safe and effective domains of this report.
- There was a lack of robust governance systems and processes in place to help ensure the safe running of the service. Without these robust systems, the provider and management team could not be proactive in identifying issues and concerns in a timely way and acting on these. The concerns found at the inspection included but were not limited to, staffing, training, care records, risk management, consent and the mental capacity act and environment safety concerns.
- We reviewed fridge temperatures and found they were consistently recorded at over 8°C. The infection prevention and control and food safety audit which took place on 31 May 2022 was ticked to say fridge temperatures were within the correct range. Staff consistently recorded that no remedial action had been taken. This meant staff and the registered manager had not picked up on fridge temperatures being in the danger zone and continued to provide potentially unsafe food and drinks to people.
- The provider failed to follow their own governance policy to ensure quality and safety. Some audits were carried out, but these were not done in line with their policy because they were not completed effectively and did not always drive improvement.

The failure to operate effective systems to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act. 2008 (Regulated Activities) Regulations 2014.

- Providers are required to act in an open and transparent way when people come to harm and to notify CQC of significant events without delay. The provider failed to notify CQC of significant events that happened in the service as required by law. This included unexplained bruising and head injuries.
- The lack of reporting had not been picked up by the provider. This meant CQC were not able to effectively monitor the service or ensure that appropriate action had been taken in relation to these incidents.

The failure to notify the Care Quality Commission of significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

characteristics; Working in partnership with others

- People were not always engaged and involved, and feedback was not always followed up on. For example, there was a survey sent to people's relatives. The registered manager told us this was not done with people because, "It is difficult due to people being non-verbal." They told us they would be looking at ways to be able to seek feedback from people in a meaningful way.
- We asked relatives if they had received any surveys to give their feedback on the service provided and if they had received feedback. Relatives comments included, "Yes I have [received a survey], I got no feedback. That is the annoying part because you want to know," "Yes, we get those [surveys] we have had no feedback," and, "Yes, we had one last year. We didn't get feedback, but we do get a newsletter." Another relative told us they had not received a survey.
- There was a lack of systems in place to evidence people were supported to express and review how they wanted their care to be provided. People were not given regular opportunity to discuss their individual care needs or wider issues in the home.
- We saw evidence for one person their culture had been considered however, in doing so, this impacted on the rights of other people living in the home. The manager told us, this did not impact on people however, two different care staff told us it did and gave us examples.
- Some staff told us they did not feel valued and listened to by the registered manager.

The failure to seek and act on feedback from relevant person and other persons on the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People care records showed people had contact with some relevant professionals for example, GP's, opticians and district nurses when required.

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 provider had a duty of candour policy that required staff to act in an open and transparent way when accidents and incidents occurred. We found this had not always been followed and concerns were not always reported to the local authority. We have reported on this in more detail in the safe section of this report.
- A relative told us about two safeguarding incidents which had occurred, they told us, "I wanted a report about what happened and never got anything back."

The failure to act in an open and transparent way was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The culture of the service did not fully reflect the principles and values of our Right support, Right care, Right culture guidance. People did not live in a suitable or homely environment. There was a lack of evidence to demonstrate how people had been empowered to have as much control over their lives as possible.
- Systems did not evidence how people were supported to express and review how they wanted their care to be provided or how the home was run. People were not involved in developing their care plans; however, their individual needs and circumstances were considered when they were developed by staff. Guidance for staff to support people to have a good day and a good week had been included and this reflected people's needs and preferences.

- We additionally noted that care plans did not include people's goals or longer-term aspirations.
- Some staff told us they felt supported by the management team however, two staff members told us they did not feel supported by the registered manager. There appeared to be a divided team which led to a poor culture. We spoke to the registered manager about this who told us they were aware of these concerns and they were working on the culture within the home and looking at ways to team build.

We recommend the provider seeks current guidance on providing person centred care and update their practice accordingly.

- People were observed to be supported by staff who cared and treated them with dignity, respect and offered general day to day choices.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents  The failure to notify the Care Quality Commission of significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent  Providing care and treatment without the consent of the person or in their best interests following mental capacity legislation was a breach of regulation 11 of the Health and Social Care Act 2008.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment  The failure to safeguard people from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment  The failure to keep premises clean and properly maintained was a breach of Regulation 15 of the Health and Social Care Act (Regulated

Activities) Regulations 2014.

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 20 HSCA RA Regulations 2014 Duty of candour

The failure to act in an open and transparent way was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

The failure to have sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The failure to assess and do all that is reasonably practicable to mitigate risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The failure to ensure safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The failure to ensure the correct management of infection control risks, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

### The enforcement action we took:

We plan to issue a Warning Notice giving 3 weeks to make the required improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The failure to operate effective systems to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act. 2008 (Regulated Activities) Regulations 2014.</p> <p>The failure to seek and act on feedback from relevant person and other persons on the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

### The enforcement action we took:

We plan to issue a Warning Notice giving 6 weeks to make the required improvements.