Mrs M Mather-Franks

The Conifers Residential Care Home

Inspection report

The Conifers
1a Lodge Road
Rushden
Northamptonshire
NN10 9HA

Tel: 01933779077
Website: www.mfcaregroup.com

Date of inspection visit:
16 January 2023
17 January 2023

Date of publication:
31 August 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Conifers Residential Care Home is a residential care home, providing accommodation and personal care for up to 10 people. The service provides support to people with mental health conditions, sensory impairments, physical disabilities and to people living with dementia. It is also registered to provide specialist support for people with a learning disability and autistic people. At the time of our inspection there were 7 people using the service.

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

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

Medicines were not always managed safely

Staff did not always follow the Mental Capacity Act key principles when making best interest decisions.

The provider did not give people care and support in a safe, clean, well equipped, well-furnished and well-maintained environment that met their sensory and physical needs. Some areas of the home were visibly dirty.

Right Care: The provider did not ensure they always had enough appropriately skilled staff to meet people's needs and keep them safe

People could not always take part in activities and pursue interests that were tailored to them. The provider did not give people opportunities to try new activities that enhanced and enriched their lives

People who had individual ways of communicating; using Makaton (a form of sign language), pictures and symbols, could not always interact comfortably with staff and others involved in their care and support because staff did not have the necessary skills to understand them.

Staff did not always receive training to enable them to meet the needs of people and keep them safe.

Right Culture: People were not always supported by staff who understood best practice in relation to the

wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. This meant people did not always receive compassionate and empowering care that was tailored to their needs

There was a lack of effective monitoring in place and this had resulted in poor outcomes for people using the service. Ineffective quality monitoring systems had failed to pick up and address the failings we identified during our inspection. There was a lack of oversight and leadership within the home.

People were not involved in developing the service. We have recommended the provider seeks advice and guidance to meet people's sensory and emotional well-being needs.

The service was not able to demonstrate they were meeting the underpinning principles of right support, right care, right culture. Staff were not aware of the right support, right care, right culture guidance.

The provider was open and responsive to concerns raised during the inspection.

Rating at last inspection and update
The last rating for this service was requires improvement (published 22 May 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the management of accidents and incidents in the service. A decision was made for us to inspect to examine those risks and also to follow up on action we told the provider to take at the last inspection.

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

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

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Conifers Residential Care home on our website at www.cqc.org.uk.

Enforcement and recommendations
We have identified breaches in relation to the storage and management of medicines, fire safety, staffing, protection from the risk of abuse, management oversight of the service and person centred care at this inspection.

We have also made recommendations to ensure the environment is developed to meet people's physical and sensory needs and for the provider to seek further support around sexuality, gender identity and sexual expression.
Please see the action we have told the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

The Conifers Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

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

Inspection team
The inspection was carried out by 2 inspectors visiting the service and 1 Expert by Experience who spoke with relatives via telephone. 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
The Conifers Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Conifers Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was not a registered manager in post. The deputy manager from another service was serving as interim manager.

Notice of inspection
This inspection was unannounced.

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

During the inspection
We spoke with 1 person living in the service and 3 relatives about their experience of care and support provided. Some people were unable to talk with us and used different ways to communicate including signs, pictures, gestures, vocalisations and body language. We observed people and their interaction with staff and each other throughout the inspection visits. We also spoke with 4 members of care staff including the provider, the interim manager, and care assistants.

We viewed a range of records held within the service, this included 3 care plans and multiple medicines records. We looked at 2 staff files in relation to recruitment. A variety of records relating to the management and oversight of the service, including staff training records, risk assessments, policies and procedures were reviewed. After the inspection we continued to receive information relating to quality assurance audits, policies and procedures. We sought clarification on staffing, staff training and competencies.

Inadequate

Is the service safe?

Our findings

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

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

At our last inspection the provider had failed to follow medical guidance, risk assessment and provide a safe environment. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made since the last inspection and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management ; Preventing and controlling infection; Using medicines safely; Staffing and recruitment

- The provider had not ensured safe arrangements for people's medicines, environment and staffing levels at the service.
- The storage of medicines was not safe. We found a range of issues which included; out of date medicines to be used in the event of a person having a seizure and medicines stored above required temperatures. The effectiveness of medicines could not be relied upon placing people at risk.
- The use of covert medicines was not managed safely. We saw 1 person had a care plan for medicines to be administered without their knowledge (covertly). The directions on how to administer the medicines was unclear. The provider had not received confirmation from the G.P or consulted with a pharmacist on how to administer the medicines. This meant the medicine may not be effective or could interact with other medicines placing the person at risk of harm.
- There were not enough staff to keep people safe. For example, records showed 1 person, needed 2 staff to support them safely in the event of emergency evacuation from the service, such as a fire. Staff told us and rotas confirmed only 1 staff member was on duty at night. This meant the person could not be safely evacuated during the night placing them at risk of harm
- The provider was not able to demonstrate timely action for people's safety when needed. Examples we found, included to mitigate risks to people from exposed hot water pipes, electrical wiring and heating equipment.
- We also found the provider had not completed remedial actions, identified in the local fire authority's fire safety inspection report from their inspection visit to The Conifers, in October 2021 and December 2022. We have referred our related findings to the local fire authority.
- At the last inspection we identified mould in bathroom areas. At this inspection we found some areas continued to have mould or stains present. Areas around toilets were wooden and did not allow for effective cleaning. The provider had not identified these areas for improvement, placing people at risk of infection.
- We were not assured that the providers infection prevention and control policy was up to date.
- We were somewhat assured that the provider was preventing visitors from catching and spreading infections.

● We were not assured that the provider was responding effectively to risks and signs of infection.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection.

We have signposted the provider to resources to develop their approach around COVID-19 practices.

● Food was not handled safely. The provider's policy said food should be tested with a probe to ensure temperatures above 80 degrees. Records showed some food had not been checked or showed food temperatures below 80 degrees. This placed people at risk of eating undercooked food. We have referred our related findings to the Food Standards Agency.

The failure to provide a safe environment, act upon and risk assess hazards in the service, manage medicines safely, ensure adequate staffing at night and prevent the risk of infection as a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

● We were assured the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.

● Staff were recruited safely. The provider had completed pre-employment and identity checks. These included employment references, a full work history with an explanation of any gaps in employment and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were not always protected from the risk of harm or abuse. Staff could not consistently demonstrate they understood how to recognise and report the witnessed or suspected abuse of any person receiving care at the service.
● People did not always feel safe. 1 person we spoke with told us someone living in the service made them sad. Staff were aware of the reason the person felt this way and failed to acknowledge the impact this may have on the person. There was no reference to this in the person's care plan, no strategies in place to support the person with their feelings or safely manage this relationship. This meant people's emotional needs were not always acknowledged or met.
● Systems were not in place to ensure people's safety when things went wrong. Regular analysis of any accidents and incidents, including where people had displayed expressions of emotional distress towards staff and other people living in the service, was not carried out to help inform and improve people's care. For example, 2 people had recently sustained a serious injury, the provider was unable to identify the cause. Information recorded regarding any incidents that occurred was limited.

Failure to ensure systems and processes were established to effectively prevent abuse of people was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Visiting in care homes
There were no restrictions on visiting. The provider was working in line with current government guidance.

Relatives told us they were welcome to visit their relations when they chose.

● Despite our findings, relatives told us they felt people were safe at The Conifers. One relative told us, "I feel [family member] is safe. I phone and they phone me if necessary."

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience
- Staff were not sufficiently trained, informed and supported to fully ensure the quality and safety of people's care.
- Since 1 July 2022, health and social care providers registered with CQC must ensure that their staff receive training on learning disabilities and autism appropriate to their role. Records showed staff had not received training in key areas including; learning disabilities and autism, dementia, safeguarding, Makaton and positive behaviour support. This meant staff did not have the knowledge and understanding to ensure people's human rights were supported or respected, this placed people at heightened risk of harm.
- Staff did not receive a structured and documented induction when they started their role. Staff told us the induction consisted of "shadowing a manager for a few days" and a 2-day training course. Staff did not complete the Care Certificate; an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. This meant staff were not supported to be competent in their roles before supporting people in the service.

This failure to ensure people were supported by staff with the appropriate skills and knowledge to keep people safe was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

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

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

relating to those authorisations were being met.

● The principles of the MCA were not always followed and people were at risk of having restrictions placed upon them unlawfully or decisions made which were not in their best interests.
● Staff did not have a full understanding of all aspects of the MCA, mental capacity assessments were not always completed in line with good practice. Records did not show how people were supported to receive and understand information when their capacity was assessed. This meant the provider could not be assured people's wishes and choices had been considered when making decisions in people's best interests.
● DoLs applications were submitted appropriately to the local authority when required. For example, the provider had assessed people to see if they were at risk of being deprived of their liberty due to the front door being locked. Following this assessment, DoLS applications were submitted for a number of people.

Adapting service, design, decoration to meet people's needs
● The environment was not adapted to promote accessibility or support people with their sensory needs.
● One person had an extra wide bedroom door, we found this to be heavy and the person would have difficulty to open this themselves. This meant they would not be able to come and go from their bedroom independently, placing restriction on their movement in the service.
● Décor did not support a person-centred approach and furnishings were plain and looked old and tired. There was no use of colour to help provide stimulation or to support with people finding their way. Communal spaces were bare, with minimal objects available for people to interact with and provide stimulation. One relative described the service as "cosy, but generally a bit lived in". This meant people were at increased risk of experiencing emotions of distress as the environment did not offer meaningful engagement or stimulation.
● Some rooms were plain and in need of redecoration and personalisation. For example, 1 bedroom was plain and had significant damage to a wall that required repair. However, 2 people had been involved in personalising their bedrooms and were excited to show us and tell us about the football theme they had chosen.

We recommend the provider seeks further advice and guidance to ensure the environment is designed, adapted and decorated to meet people's physical and sensory needs, to include supporting people to personalise their bedrooms.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider failed to assess people's needs and choices. Staff did not have consistent information about people or their current needs in order to provide optimal care and support to everyone living in the service.
● Care plans contained limited information and had not been updated in over 6 months. 1 person's moving and handling plan was last reviewed in 2021. Risks were highlighted by underlining words, however there was no explanation to describe the impact this had on the person or how to reduce any risk.
● Sexuality care plans failed to explore people's sexual needs and identity and did not consider choice in an appropriate manner. For example, 1 person's care plan stated their need to recognise their gender identity, however, did not state how they identified, only that they recognised their gender and 'dressed accordingly'. The provider did not recognise gender identity and clothing choice as separate. The person's gender identify was presumed and not explored further, this placed people at risk of discrimination.

We recommend the provider seeks further guidance around sexuality, gender identity and sexual expression

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support
● People were supported to attend health appointments by staff who knew them well when needed.
● People had key care information summary sheets, which they took with them, if they needed to transfer to another care provider. This helped to ensure the person received consistent care and support when they needed to move between services, as agreed with them.
● We saw a pictorial guide to demonstrate to people how COVID testing is completed and why it is important. This was used when people were displaying symptoms and helped to put them at ease and understand the testing process.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough to maintain a balanced diet.

● People were involved in choosing their food and planning their meals. Staff held weekly meetings with them, where meal choices were discussed and planned for the upcoming week. Assessments were completed to identify any concerns about a person's weight which included actions for staff to take to reduce any risks.
● One person had been assessed as needing a softer diet by a speech and language therapist. There was clear guidance in place for staff to follow. We spoke with staff who were able to explain the guidance and what it meant for the person.

Requires Improvement

Is the service caring?

Our findings

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

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

Respecting and promoting people's privacy, dignity and independence
- People were not always treated with dignity and respect when they received care from staff.
- During the inspection we saw 1 person was walking around the lounge, we observed a member of staff take the person by the wrist to sit them on the sofa. The staff member did not engage with the person or give them any choices. This did not support the person in a dignified way. We raised this with the interim manager during the inspection who said they would investigate this concern.
- People's care plans did not promote dignified care and support, and often included language that was disrespectful and not inclusive or understanding of the person's communication needs. For example, 1 person's care plan used language such as, 'Stomps about,' and, 'I can become aggressive at times'. Their care plan did not consider what the person may be experiencing or expressing when they presented in this way or provide appropriate guidance for staff on how to respond effectively, to help reduce the person's distress.

Ensuring people are well treated and supported; respecting equality and diversity
- People's care plans were not always personalised to include information about people's likes and dislikes so their needs, wishes and preferences could be respected in relation to their care and living arrangements.
- Some staff were very caring towards people and talked about them with affection. They told us they thought of people living in the service being like family members. We observed during lunch time, staff demonstrated kindness and patience when supporting people with their meals.
- Relatives were generally positive about the care people received. One relative told us they, "feel the care is good." Another said, "The staff are lovely, always welcoming."

Supporting people to express their views and be involved in making decisions about their care
- The provider failed to ensure people and those important to them were fully involved in their care and related decision making.
- The provider sought feedback from people but did not consistently act on this. Records showed staff held weekly meetings with people to gain their views. For example, people were asked about what activities they would like to do the following week or what meals they would like on the menu. We saw the menu was tailored to people's requests, however, did not see evidence that requests around activities and engagement took place.
- People and relatives were not fully involved in reviews. Relatives told us they were aware that reviews had taken place but had not been fully involved. One relative said, "I have not received the paperwork. We did not find evidence of people's views being included as part of a structured care review. This meant

opportunities could be missed to ensure people received person centred care.

Requires Improvement

Is the service responsive?

Our findings

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

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

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

- People's needs were not consistently met in an individualised way that fully ensured their equality, rights, autonomy and inclusion in their care and daily living arrangements.
- We observed people were often redirected to the lounge to sit in front of the TV. People were not offered alternative activities to choose from or asked what they would like to watch. We observed 1 person repeatedly stand up and move away from the TV, indicating they may not wish to engage in this way. Staff did not respond or attempt to support the person to engage in any alternative activity.
- Staff were not supporting people to identify their goals and aspirations, so the outcome was doing the same things as they always had done. This included to ensure regular opportunities for people to meet with others who held the same interests as them, outside the home. Records showed the only outside interaction people had was attending a day centre held in the provider's other care service.
- People's feedback was not regularly listened to or acted on. Records of weekly meetings held with people showed they wanted to go out more, to do things such as visit the local pub or coffee shop and to go shopping. Staff did not support people do these activities in line with their preferences. Records showed people spent a lot of time watching TV with no evidence of alternatives offered.
- People were not supported to develop and flourish. During the inspection we observed there was minimal interaction from staff with people. We observed people sat for long periods of time doing nothing, with no alternative choices offered. On both days of the inspection, staff did not attempt to engage people with any activity.
- One person's care plan showed they enjoyed going swimming, to the gym and using a bike. There was no related record of them being given opportunities to take part in these activities. One relative told us "[person] likes playing table-top games in a local café but I think they need more stimulation". This meant people did not always have choice and control over their lives and did not receive consistently person-centred care.

The provider had not ensured people received personalised care, which was appropriate, met their needs and reflected their preferences. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- People's emotional needs were not always prioritised or met. One person told us they felt sad and said this was due to the behaviour of another person living in the service. We have made further reference to this in the safe section of the report.

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

● The Accessible Information Standard was not being met.
● People's communication needs were assessed, but there was no clear guidance in people's care plans about how staff should meet these. Where there was guidance, this was not always followed and was not up to date. For example, 1 person's care plan said the person could understand gestures and used objects of reference to communicate, however there was no guidance for staff to use these methods appropriately and effectively.
● People's support plans and recorded minutes from meetings held with them by staff were not available in accessible formats. For example, meeting notes were not made available in any alternative formats, such as easy read. This meant people who required alternative formats would not be able to be as involved in decisions about the service or be aware of the views of others who participated in the meetings.

End of life care and support
● The provider had a policy in place for when end of life care was required. No one was receiving of end of life care at the time of the inspection.
● The providers training records confirmed staff had received training in end of life care.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy in place. We found there had been no complaints or concerns raised in the past 12 months.
● Relatives told us they would feel confident to raise a compliant and felt sure it would be dealt with appropriately. One relative said, "I have never made a complaint, I have no concerns."

Inadequate

Is the service well-led?

Our findings

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

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

At our last inspection the provider had failed in the oversight and management of the service This was a breach of regulation 17 (Good governance) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made and the provider was still in breach of Regulation 17.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider's governance arrangements did not effectively ensure the quality and safety of people's care, or timely and continuous service improvement when needed.
- A lack of quality assurance checks of people's care files meant issues such as the poor quality of mental capacity assessments, lack of regular reviews and insufficient person centred planning, had not been identified or rectified.
- Systems to assess, monitor and drive continuous improvements of the service were ineffective. Risks to people were not always identified or addressed. This included improvements we identified were needed at our last inspection and at this inspection of the service. For example, in relation to people's medicines, environmental safety, record keeping and for infection prevention and control.
- The provider had not promoted an open and supportive culture for all people living in the service. There were signs of a closed culture, in which people's needs were not placed at the heart of care practices and people were not involved in their support. Staff were not provided with sufficient support to enable people to live the way they preferred, and which safely met their needs.
- The provider had not identified staff had not received sufficient training to carry out their roles safely. They had not identified the staff training matrix was ineffective as not all staff members were listed on it. The provider could not assure themselves staff were able to provide safe care or keep people living in the service safe.
- The provider failed to implement and embed the principles of Right Support, Right Care, Right Culture in the service for the benefit of people living there. People were not supported to set or achieve personal goals or follow their interests and past times. People were not enabled to develop or flourish. The provider and interim manager told us they were not aware of CQC's principles around Right Care, Right Support, Right Culture.
- The provider had not identified or acted to ensure person centred arrangements and adaptations for

people's care and their environment in accordance with their needs. People were not effectively involved or consulted to inform their care and related decision making in relation to the development of the service.
● Policies and procedures were generic and not tailored to the service. These had not been regularly reviewed. The provider failed to follow their own policies in relation to areas such as quality assurance and room temperature monitoring. Updated guidance was not incorporated into policies to ensure staff were following best practice guidance to ensure the best outcomes for people. For example, the provider's medication policy did not give clear guidance to staff when seeking to administer a persons' medication covertly.

The service was not effectively managed or led The systems and processes to assess, monitor and improve the quality and safety of the service were not established or operated effectively. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider did not have a registered manager in place at the time of the inspection. They were in the process of recruiting a new registered manager. A deputy manager from another service was providing management support in the interim with the support of the registered provider.

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 did not understand their responsibilities in relation to the duty of candour. The provider told us there had not been any incidents that met these criteria, however we were aware of 2 recent serious injuries where the duty of candour applied.
● The provider submitted notifications to CQC and other agencies appropriately, as required by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider did not have systems in place to fully ensure people's feedback was listened to and acted upon. Regular meetings were held with people using the service, however feedback from the meetings was not effectively shared with people or acted on. For example, we saw people had requested trips out of the service, however records showed these trips did not take place.
● Relatives were happy with the care (their relative) people received. One relative told us, "[Staff] are lovely, they're always welcoming" and "[relative] is happy, that's all that matters, [staff] are like a family to them".
● Staff were positive about the provider and interim manager. They told us they felt supported and felt able to speak freely with them. Staff said, "We can go to [provider] with any concerns and they get sorted" and "[manager] is always happy to support, can call them anytime , if I'm not sure about something".

Working in partnership with others
● Staff worked with external agencies involved in people's care when needed, this included G.P's, advanced nurse practitioner, speech and language therapists, to ensure people were supported by a range of health professionals.
● The provider was receptive to the concerns we raised during the inspection and took some action to address the immediate concerns raised with them, replacing the kitchen fridge and making arrangements for the fire doors to be serviced.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Failure to acknowledge and mitigate risk around emotional needs, provide choice and control for service users, failure to ensure communication needs were met, failure to provide an environment suitable for people with learning disabilities and autism

The enforcement action we took:

We varied the providers condition of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Not all staff were interacting with people in a dignified manner, records used derogatory language to describe people

The enforcement action we took:

We varied the providers condition of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to assess risk, provide safe staffing levels at night, manage food safety, manage medicines, complete fire checks, provide a safe environment

The enforcement action we took:

We varied the providers condition of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Failure to safeguard people from abuse

The enforcement action we took:

We varied the providers condition of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Widespread failures across the service, multiple breaches of regulations, failure to ensure effective quality assurance systems in place, ensure clear and concise records

The enforcement action we took:

We varied the providers condition of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failure to ensure staff received appropriate training

The enforcement action we took:

We varied the providers condition of registration