S.M.S. Care Limited

SMS CARE LIMITED

Inspection report

17a Gorse Road
Blackburn
Lancashire
BB2 6LY

Tel: 07889984547
Website: www.smscare.co.uk

Date of inspection visit:
06 June 2023
08 June 2023
30 June 2023
03 July 2023

Date of publication:
06 November 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
SMS CARE LIMITED is a residential care home providing accommodation for persons who require nursing or personal care for up to 11 people. The service provides support to people living with learning disabilities or autistic spectrum disorder. At the time of our inspection there were 6 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: Model of Care and setting that maximises people's choice, control and independence

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. DoLS assessments, care planning and risk assessments had not been completed.

Safeguarding allegations were not being acted upon or managed appropriately, referrals were not being made to the relevant authorities.

Medical assessments and reviews were not always completed. There was no record missed appointments had been followed up. Professionals told us the service did not engage with them.

We saw some basic activities taking place. People told us they accessed community activities including a recent holiday to Blackpool. Records had not been developed to confirm activities had been undertaken.

People's communication needs had been considered.

Right Care: Care is person-centred and promotes people's dignity, privacy and human rights

Medicines were not managed safely. Individual risks were not being assessed or managed safely and accidents and incidents were not actioned safely or lessons learned.

Some improvements were needed in relation to infection prevention and control.

Weights were not being recorded appropriately and one person's individual needs in relation to their meals had not been provided. Supplies of fresh food was limited and some foods were not stored in line with

guidance and the kitchen cupboards were disorganised. People told us they were happy with the meals they were provided.

People told us they were happy with the care they received however, the feedback from relatives was mixed. One person's care record was stern and derogatory in their content. One person was concerned about a medical need, staff did not act on this.

Care records were incomplete, basic or inaccessible and failed to provide information and guidance to support people's individual needs. Preadmission assessments were not seen. People and some relatives told us they were involved in decisions about their care. End of life care plans had not been developed. None of the staff had undertaken end of life training.

Policies and procedures were in place electronically and were up to date

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.

No environmental risk assessments were completed. Fire safety had improved. We have made a recommendation about ensuring the environment was safe for people to live in.

Staffing was insufficient to meet the needs of the people and the service, and staff were not always recruited safely, agency profiles were incomplete. Gaps in staff training was evident and supervisions were not undertaken regularly.

A system had still not been developed to ensure complaints or concerns were managed. People told us they were happy and knew how to raise concerns. The service had not acted when things went wrong.

Systems to ensure quality oversight and governance had not been developed. Very little audits had been undertaken and no senior audits were done. The service was not submitting statutory notifications when incidents had occurred, as required.

Professionals raised concerns about the service and a number of professionals meetings were held to discuss the concerns.

Evidence of meetings with staff and people were seen and surveys had been conducted. However, the findings had not been reviewed or action taken.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 21 January 2023).

We issued the provider with a warning notice asking them to make improvements in relation to safe care and treatment and good governance. The provider completed an action plan after the last inspection to show what they would do and by when to improve in relation to requirements. At this inspection we found the provider remained in breach of regulations.

At our last inspection we made recommendations in relation to, infection prevention and control, supporting people to eat and drink enough to maintain a balanced diet, ensuring consent was obtained and

people were protected from unlawful restrictions. We also recommended people were supported with activities, care plans which reflected people's needs, and the management of complaints or concerns. The provider had acted on some of the recommendations but not all.

Why we inspected
This inspection was prompted by a review of the information we held about this service and to follow up from the previous inspection.

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

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, response 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for SMS CARE LIMITED on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to people's dignity, people's end of life care needs and the support available to access activities of their choosing. We also identified breaches in relation to risk, monitoring of people's individual needs and the safe management of medicines.

We also identified breaches in relation to unlawful restrictions and to ensure safeguarding concerns were reported and monitored and people were exposed to the risk of harm as they were not support with their meals safely. The provider had not developed systems to investigate and manage complaints, failed to ensure care records directed staff in relation to their individual needs and how to manage them as well as ensuring detailed assessments took place for people. The provider failed to ensure sufficient numbers of suitable staff were in place, that staff received appropriate support, training and as is necessary to enable them to carry out the duties they are employed to perform. We also identified breaches in relation to good governance and ensuing statutory notifications are submitted to CQC where required.

We have made recommendations to support changes so the service is suitable and safe for people to live in and that people have access to meaningful activities.

Regulatory enforcement action was taken, no representation or appeals were received as a result of this action. We have therefore cancelled the providers registration.
Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

SMS CARE LIMITED

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
Three inspectors, 1 medicines inspector and 1 Expert by Experience undertook the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector and 1 medicines inspector visited the service on 6 June 2023, 1 inspector visited on 8 June 2023, and 2 inspectors visited the service on 3 July 2023.

Service and service type
SMS CARE LIMITED 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. SMS CARE LIMITED 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 no registered manager in post. There was a temporary manager, who was also the temporary regional manager. They confirmed they would remain at the service until a suitable manager was recruited.

Notice of inspection
This inspection was unannounced. Inspection activity started on 6 June 2023 and ended on 3 July 2023. We visited the service on 6 and 8 June and 3 July 2023.

What we did before the inspection
We looked at the information we held about the service. This included, feedback, notifications and the actions taken by the provider since the last inspection. We asked for feedback from professionals about the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We undertook a tour of the building, including communal areas and some bedrooms. We spoke with 4 people who used the service and 3 relatives on the telephone. We spoke with 3 visiting professionals as well as a range of professionals as part of multi-agency meetings as a result of concerns raised. We undertook observations in the communal areas. We spoke with 7 staff members. These included 4 care staff, the temporary manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We looked at a range of information. This included 5 care records, 5 medicines administration records and associated documents. We also checked staff files, training records and information about the operation and management of the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure systems were in place to demonstrate that risks were properly managed. This was a breach of regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection, and the provider was still in breach of regulation 12

- Risks were not assessed or managed safely, lessons were not learned.
- People's individual risk assessments failed to ensure staff had information and guidance to protect them from harm. Paper records were incomplete, basic missing to manage people's risks. For example, one person had a medical need. The risk assessment failed to provide accurate information about how to manage the condition if concerns were identified.
- The service was in the process of transferring people's care records onto an electronic system. None of these records had risk assessments for three of the people in the service. Staff were unable to access people's risk assessments as they had not been transferred and were not accessible to staff.
- The manager was unable to provide completed accident reports where these had occurred. One accident report which had been completed had no evidence of the actions taken, if this had been followed up by the management, or if any lessons had been learned. The care plan and risk assessment had not been updated to reflect the accident.
- The manager told us environmental risk assessments were being completed, we asked to review these. We saw guidance and policy for completing these however, no completed risk assessments were provided.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Fire safety checks were being completed. These included weekly fire checks, fire risk assessment and a signing in book had now been introduced. We saw improvement had been made in relation to an external professional fire safety review. Personal emergency evacuation plans (PEEP's) were in place for people living in the service.

Using medicines safely

At our last inspection the provider had failed to administer or store medicines safely. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● The service had insufficient numbers of trained staff to administer medicines competently. Untrained staff had signed for administering medicines on 30 occasions and on six nights when no competent staff were on duty from May to July 2023.
● We saw gaps in records where medicines had been missed, with no explanation for the omission.
● The service had made changes to ensure some medicines were stored safely and securely, however the fridge and storage room temperature was not being monitored. Following the inspection the service put systems in place however, records showed temperatures were out of range and no action was taken.
● The service did not conduct any medicines audits to monitor their performance.

The provider had failed to ensure safe systems for the management and administration of medicines. We found no evidence people were harmed at the time of the inspection, however, unsafe management of medicines placed people at increased risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives were happy with their medicines. Comments included, "[Person] does take medication and I couldn't say what exactly. But I do know staff do this for [person] and we've not had any problems", "[Person] does take medication and the staff help them with that" and, "[Person] is safe with medication."

Staffing and recruitment

At our last inspection, the provider had failed to ensure robust recruitment procedures, were in place. Monitoring of staff ensure they were able to carry out the duties required of them was also in need of improvement. This was a breach of Regulation 19 (1) Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19

● Staff were not recruited and supported safely.
● Sufficient numbers of staff were not in place to support people's need safely. Most of the staff were not directly employed by the service and were long term agency staff.
●Duty rotas identified staff were working excessive hours and long shifts. One staff member had worked a 20 hour shift and a second had only 1 day off during a three week period. Some staff were working over 60 hours in a week. There was no record in staff files to confirm they had signed to opt out of the 48 hour work time directive.
● Staff files had been developed however, not all information in relation to the recruitment process was included. Some of the agency profiles provided had been dated as completed on the day these were requested and not all had photographs of the staff member on them.

The provider failed to ensure suitable staff were in place. This placed people at risk of harm. This was an ongoing breach of Regulation 19 (1) (2) (3) Fit and proper persons employed of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

● Staffing numbers were not sufficient. Relatives expressed concerns about staffing levels and staff turnover. They told us, "There is a lot of staff that keep changing and that is hard for [person]. If staff don't know and understand [person] then they won't be able to know [person]", "All the staff seemed to leave and it just hasn't been the same. I can't put my finger on it exactly. I think [manager] is trying hard to get the right staff" and, "There is still not enough staff, even though the manager is trying. I know it has to be the right staff. I don't know how many need 1-1, but two staff is not enough."
● One relative told us their family member had recently had an increase in support hours. We asked the manager about this who told us this was for daytime activities. However, there was no evidence in the duty rotas who was responsible for these one to one hours, or details in the persons care records. We asked for a copy of the staff dependency tool that demonstrated enough staff was in place to meet people's needs. This was not provided.

The provider failed to ensure sufficient numbers of suitable staff were in place. This placed people at increased risk of harm. This was an ongoing breach of Regulation 18 (2) (a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure safeguarding procedures had been established effectively to protect people from the risk of abuse. This was a breach of regulation 13 (1) (2) (3) Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13

● People were not always protected from the risk of abuse. A safe system had not been developed to ensure allegations of abuse were recorded, acted on, investigated and lessons learned as a result of the findings. Where safeguarding concerns were being investigated by the Local Authority, there was no record about the concerns or the actions taken to ensure people were protected from the risk of abuse, other than minutes from team meetings.
● Incident reports identified a concern for one person which required a referral to the Local Authority safeguarding team and a notification to be submitted to the Care Quality Commission. There was no record to confirm this had been done or any actions taken to protect them from future risks.
● Conflicting information about the number of safeguarding concerns was provided by the manager.

People were at risk of harm because the provider failed to ensure systems were robust enough so that safegaurding concerns were reported and managed. This was an ongoing breach of Regulation 13 (1) (2) (3) (4) Safeguarding people from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● None of the people or relatives raised any safeguarding concerns. Staff told us they felt people were safe living in the service. The training matrix confirmed the staff team had undertaken safeguarding training. However, the management team had not been recorded on the record to confirm they had undertaken the relevant training.

Preventing and controlling infection

At our last inspection we recommended the provider consider current guidance on ensuring people are protected from the risks of infection and act to update their practice. The provider had made some improvements.

● We were somewhat assured that the provider was responding effectively to risks and signs of infection. One person required staff to inform professionals to visit to reduce an infection risk. Visiting professionals told us staff failed to inform them when this was required.
● We were somewhat assured that the provider was supporting people living at the service to minimise the spread of infection. One relative told us cleanliness in the service had improved recently but that it was a lot cleaner when there was dedicated housekeeping staff.
● We were assured that the provider was using PPE effectively and safely. We asked the provider to review guidance in relation to wearing PPE in the service.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The service ensured visitors were supported to visit, and we saw visitors during the inspection.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection, the provider had failed to ensure staff received appropriate support, training, as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 (2) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18

- Staff were not supported or trained appropriately.
- Staff told us they had undertaken training. However, training records had significant gaps which demonstrated staff had not undertaken all relevant training to support them in their role. For example, none of the staff had undertaken learning disability training, end of life care or blood sugar monitoring. The training matrix had no records to confirm the management team had undertaken any training to support the delivery of care to people.
- We asked for copies of supervision records to confirm staff were supported and monitored in their role. However, the last date for these was from December 2022 and none of the records provided were for the staff currently working in the service.

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

- People raised no concerns about the knowledge of the staff team.

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

At our last inspection we recommended the provider considered current guidance on ensuring people's diet and fluid needs were assessed and monitored.

During this inspection the provider had not made improvements and was in breach of regulation 14

● People were not consistently supported to eat and drink.
● One person required one to one monitoring whilst they had their meal. We observed a staff member leaving the person to eat alone. We asked the staff member about this who was unable to explain the reason for the action they took. Another staff member had to direct them to return to support the person safely. This meant people were at increased risk as guidance to support people safely was not followed.
●We checked the weight records for people and saw these were not being completed regularly. One person's record had only one entry recorded in one month and there was no year recorded to confirm when this had been done.
● Professionals told us people were not being provided with enough food and fluids and the quality of the food provided was poor. Supplies of fresh food was limited in the fridges and the manager told us they were waiting for a delivery of food. However, the supply of fresh food was still low on the second day we visited. Most meals provided were frozen ready meals. Food was not being stored in line with guidance in the fridges, dates were not recorded on an opened and uncovered plate of food. Kitchen cupboards were disorganised and food and crockery were mixed together.

Whilst no harm occurred people were exposed to the risk of harm as they were not supported with their nutritional needs safely. This was a breach of Regulation 14 (1) Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Meals were prepared by staff on each shift and people told us they sometimes were involved in the preparation and cooking of meals. There was a menu for the week on display in the kitchen and information in relation to taster sessions for people. We observed the evening meal time experience on one of the days. There was basic interactions between staff and people and no choice of meal was offered. However, people told us they had enjoyed their meal.
● People said they were happy with the food they received. One commented, "The food is great I get what I want to eat." Relatives told us people were happy with their meals. One said, "They enjoy their meals so they must be Okay." However, one relative said, "I don't know about the meals now."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were not always provided with appropriate support for their individual health needs.
● During our inspection one person told us about a concern which required a medical review. We spoke with the manager about this who assured us they would seek a medical review without delay. However, a visiting professional advised us that this had not been actioned and that they had not done this.
● Records contained information about the involvement of professionals. However, care records did not always reflect support from them. We saw professionals visiting during the inspection. However, professionals told us the service failed to engage effectively with them ensuring people's individual needs were being met and that they had taken action to ensure people were safe.
●Relatives feedback about the involvement of professionals and any changes in people was inconsistent. One said, "They don't keep me informed about anything. I don't know anything unless I ask." Another told us they supported their family member to attend medical appointments.
● We saw evidence of appointments with health professionals. However, one person's record detailed missed appointments had occurred. There was no record these had been followed up.

Systems were not in place to ensure people were protected from the risks associated with inadequate monitoring of their individual needs. This placed people at increased risk of harm. This was a breach of Regulation 12 (1) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People and relatives told us they were mostly involved in decisions about their care.
● We saw no evidence of completed preadmission assessments in the records we looked at. We discussed one person's specific needs with the manager following concerns being raised by professionals about whether the service was able to meet their needs. The manager was unable to demonstrate that a robust assessment had taken place to ensure the service could meet their needs.

Systems were not in place to ensure detailed assessments took place for people prior to admission. This placed people at increased risk of harm. This was a breach of Regulation 17 (2) Good governance 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.

At our last inspection we recommended the provider considered current guidance on ensuring records were up to date and guided staff on protecting people from unlawful restrictions and obtaining consent and take action to update their practice accordingly.

During this inspection improvements were still required and the provider was in breach of regulation 13

● Consent to care and treatment in line with guidance and the law was not always in place. We saw evidence of some DoLS applications however, not all people's records had details of applications to ensure they were not being deprived of their liberty unlawfully. One person's authorisation had expired and there was no evidence that a detailed follow up application had been submitted.
● A professional told us the service had failed to engage in the DoLS assessment process for one person. Where an application had been submitted for one person no care plans, risk assessments or capacity assessments had been undertaken.
● There was evidence in the care records that consent had been obtained. However, one person's record had been signed by a previous staff member as their representative.

People were not always protected from the risks of unlawful restriction. This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they were asked for permission from staff before undertaking any activity.

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

● Some improvements had been made since the last inspection, however, further improvements were required. Checklist and handover records in relation to the environmental safety checks had not been completed consistently The buzzer system had been muted on the first day of the inspection and two of the buzzers were not working. We also noted one persons bed was very chipped, posing a risk. The provider took immediate action to address our findings.

We recommend the provider seeks nationally recognised guidance to ensure the service is suitable and safe for people to live in and take action to update their practice accordingly.

● A relative raised some concerns about the temperature in a bedroom. We asked the provider about this who told us they had completed repairs. During our observations all areas were noted to be warm.

● People told us the provider had made improvements and they had decorated their rooms as they wished. We saw evidence of personalisation in people's bedrooms. On going decoration and improvements were noted. Maintenance was taking place in the laundry to install a sluice wash facility.

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.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People's dignity and independence was not always promoted.
- We undertook observations and saw some kind interactions between staff and people.
- Staff were not always responsive to people's requests. One person told us about a concern they had about a physical change in their condition. The staff we approached about this did not explore this further and dismissed the persons concerns as behavioral.
- One person's care records was written in a derogatory manner and lacked empathy.
- A relative told us they were concerned staff did not always identify when people's confidence with personal care was changing. One relative told us, "I'm just not as happy about the home (service) as I used to be." Another relative told us that the service could do more to support their family members independence.

The provider failed to ensure staff supported people's individual care needs. This was a breach of Regulation 9 (1) Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- All of the people told us they were happy with the care. They told us, "I am happy" and, "It is much better than last time you came." Relatives told us, "[Person] seems happy enough it has been okay", "[Person] seems to have remained happy throughout." However, one relative told us, "They used to mix more with staff all together and have a bit of a laugh. That doesn't happen now. [Person] is happy, but not as happy."
- Advocacy information was available. Advocacy seeks to ensure people are able to have their voice heard on issues that are important to them.
- People's privacy was promoted, personal care was delivered in people's rooms and people told us they were able to lock their bedrooms as they chose.
- Up to date policies and guidance about the delivery of care had been developed. People's personal information was mostly stored securely and passwords were in place on electronic systems.

Inadequate

Is the service responsive?

Our findings

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

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

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

At our last inspection we recommended that the provider consider current guidance on ensuring care plans reflected people's individual needs and how to support them.

During this inspection the provider had not made improvements and was in breach of regulation 17

● Personal care had not been planned to support people's choice and control to meet their needs and preferences.
●People raised no concerns in relation to their involvement in decisions about their care. We received mixed feedback from relatives. Some told us they were informed about decisions. However, others told us, "Staff seem to listen when you mention things, but nothing gets done" and, "They don't keep me informed about anything. I don't know anything unless I ask."
● Care records were incomplete, inconsistent, too basic or failed to guide staff about how to support people's individual needs. For example, one person who had a medical diagnosis had no care plan or risk assessment to ensure they received appropriate care.
● The manager told us they were in the process of transferring care plans and risk assessments onto the electronic system. We saw a number of these had not been updated on transfer and been copied from the paper records, and no risk assessments had been completed.
● Daily records were being completed however, not all were completed in full, or gaps were evident in the recording. For example, where one person was being supported with positional changes, there was no record to confirm this had taken place.
● Handover records had been developed to record the activities undertaken for people. However, two records we asked for were not provided and staff completed the handover record retrospectively on one of the days we visited.

The provider failed to ensure care records directed staff in relation to people's individual needs and how to manage them. This was a breach of Regulation 17 (1) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● People's end of life support was not managed effectively.
● None of the care files had care plans or risk assessments in place to support people's end of life needs. None of the staff had completed end of life care training, this was despite people living in the service who

had end of life care needs.
● Records of DNACPR (do not attempt cardio pulmonary resuscitation) were seen for some people. However, copies of these were in their bedrooms and had not been secured. This meant these were readily available to anyone who entered their room.

The provider failed to ensure people's end of life care needs were supported. This was a breach of Regulation 9 (1) Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

At our last inspection we recommended the provider consider current guidance on ensuring a robust system was in place for recording and acting on complaints. During this inspection we noted further improvements were required and the provider was in breach of regulation 16

● Complaints and concerns were not always acted upon appropriately.
●We asked to look at the system to manage complaints. The manager told us they had recently introduced a system for recording and managing complaints. We received feedback that a complaint had been raised several months prior to the inspection. However, we saw no evidence of any complaints or actions taken to address concerns. This meant that the service still had no system in place for recording and acting on complaints.

Systems were not in place to investigate and manage complaints. This was a breach of regulation 16 (1) receiving and acting on complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they were happy and raised no concerns. One relative said, "I'm not a complainer. I would talk about it first to staff" and, "I have no complaints."
●The provider had introduced a comments and suggestions box in the entrance. They told us this had helped to improve options to provide feedback.
● Policies and procedures were available in relation to the management of complaints.

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

At our last inspection we recommended the provider consider current guidance on ensuring plans were developed in relation to planned activities, and people were supported to access meaningful activities of their choosing.

Some improvements were noted in the development of plans and an activities programme. However, improvements were required in relation to activities.

● People were sometimes supported to be engaged and involved in activities of their choosing.
● Feedback from relatives was mixed about the activities provided. They said, "I think the residents (People who used the service) can come and go as they please", "[Person] is at home there. [Person] has just been on holiday to Blackpool for a few days. They do that a couple of times a year" and, "I know they look after [person] but they need to let [person] do more." One relative told us that previous celebrations such as family birthdays were not being celebrated as they used to.

● There was some evidence of activity plans in people's records and on display. However, records to confirm what activities had been undertaken had not been completed for several months. One relative told us, "When we ask [person] they say no [person] hasn't done any of those things (activities)." We saw very little activities taking place during the inspection, other than one person helping in the garden and individual activities for people on their own.

We recommend the provider consults nationally recognised guidance to ensure people have access to meaningful activities.

● People told us they undertook activities and talked with fondness about a recent holiday to Blackpool.

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.

● People's communication needs were supported. Good detail was noted in some people's care plans to support them to communicate effectively. Pictorial aids were used and plans were in place to undertake British Sign Language training.
● Some relatives raised some concerns about the skills of the staff team's ability to communicate effectively with people. We observed most staff communicating effectively with people during the inspection.
●Wi-Fi was available and technology was being used in the service.

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 inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Working in partnership with others

At our last inspection the provider had failed to ensure systems were in place to ensure good governance. This placed people at risk of harm. This was a breach of Regulation 17 (2) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● There was insufficient oversight and governance of the service. The provider had not acted when things went wrong.
● We asked the manager several times for a range of information. Not all of this was provided.
Robust audits, monitoring and reviews were not taking place, other than for infection control. Some basic checks had taken place, for example fridge and room temperatures. However, there was no guidance for staff to follow and where these were out of range they had not been followed up by the management. We asked for details of provider audits undertaken. The manager told us none had been completed.
●Since the last inspection, the provider had developed an action plan to address the findings. However, some of the information relating to actions was brief and incorrect. For example, it recorded a schedule for supervisions had been developed. However, the most recent supervisions were dated from December 2022.
● During this inspection we identified widespread failings already identified in this report. The provider failed to ensure staff supported people's dignity and independence. They failed to ensure people's end of life care needs were supported and to ensure systems were in place so people were engaged and involved in activities of their choosing. The provider also failed to ensure systems were in place to protect people from the risks associated with their care. This included inadequate monitoring and the safe management of medicines administration. We also identified breaches in relation to unlawful restrictions and failing to ensure systems in place were robust enough to monitor safeguarding concerns and received appropriate support with their meals. These failings had not been identified by the provider prior to our inspection.
● We also identified breaches as the provider had not developed systems to investigate and manage complaints, failed to ensure care records directed staff in relation to their individual needs and how to manage them as well as ensuring detailed assessments took place. Sufficient numbers of suitable staff were

not in place, staff did not receive appropriate support, training and support. These failings had not been identified by the provider prior to our inspection.

Systems were not robust enough or developed to demonstrate good governance. This was a breach of regulation 17 (1) (2) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider was failing to respond to concerns. We were advised of some safeguarding referrals that had been made to the Local Authority. The service had also failed to ensure statutory notifications where submitted to the Care Quality Commission where required in line with their statutory responsibilities.

Systems had not been developed to ensure notifications were submitted to the Care Quality Commission without delay. This was a breach of regulation 18 (1) (2) Notification of other incidents of the Health and Social Care Act 2008 (Registrations) Regulations 2009

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care
● A person-centred and open culture which supported good outcomes for people had not been developed. Continuous learning and improving care was not effectively managed.
● Professionals raised a number of concerns about the operation and management of the service and the safety of people. Several meetings had been held with a range of professionals in relation to significant safety concerns and the management of these. Action had been taken by professionals to ensure people were safe.
● There was an on call system covered by the manager and nominated individual. However, the manager did not live locally and the nominated individual had not undertaken any care training to enable them to provide support if required. This meant staff did not have adequate access to senior support out of hours if it was required.

Systems were not robust enough or developed to demonstrate good governance. This was a breach of regulation 17 (1) (2) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Most relatives were positive about the manager. One told us, "The new manager, [name] he's ok and is doing his best to get everything in order." People told us they were happy with the new manager and the changes they had made. Staff were complementary about the manager and the support they provided.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and staff were engaged and involved. Relatives told us they had been asked for their views. Comments included, "I've had questionnaires two or three times a year I would think. A box ticking form really" and, "We do have questionnaires but not for a while. Once a year maybe. Nothing I know has improved because of them."
●Satisfaction surveys had been completed recently. Notes and feedback were recorded. However, there was no record to confirm the surveys had been reviewed or an action plan to address the findings had been developed.
●We saw records to confirm regular meetings were taking place for people and staff. Notes and pictorial aids on the topics discussed were seen. The manager told us they had a group message system to share updates with the staff team.

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 provider failed to ensure statutory notifications were submitted to the Care Quality Commission without delay. Regulation 18 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure staff supported people's individual care needs. The provider failed to ensure people's end of life care needs were supported. Regulation 9 (1) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to protect people from the risk associated with inadequate support with their meals. Regulation 14 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

The provider failed to ensure systems were in place to investigate and manage complaints.

Regulation 16 (1) (2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the safe management of medicines. Regulation 12 (1) (g) The provider failed to ensure systems were in place, completed and action taken in relation to risks. Regulation 12 (1) (a) (b) The provider failed to ensure systems were in place to ensure people were protected from the risks associated with inadequate monitoring of their individual needs. Regulation 12 (1) (2) (a) (b)

The enforcement action we took:

NoP for cancellation of registration reg 17

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure people were protected from the risks of unlawful restriction. Regulation 13 (5) The provider failed to ensure systems in place were robust enough, effective and that safeguarding concerns were reported and monitored. Regulation 13 (1) (2) (3) (4)

The enforcement action we took:

NoP for cancellation of registration reg 17

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure care records directed staff in relation to their individual needs and how to manage them. Regulation 17 (1) (2) (b) (c) The provider failed to ensure systems or processes were established and operated effectively to assess and monitor the service. Regulation 17 (1) (2) (a) (b) The provider failed to ensure system were in place to ensure detailed assessments took place for people. Regulation 17 (2) (a)

The enforcement action we took:

NoP for cancellation of registration reg 17

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to protect people from the risk associated with inadequate support with their meals. Regulation 14 (1) (2) (a) (b)

The enforcement action we took:

NoP for cancellation of registration reg 17

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitable staff were in place. The provider failed to ensure systems were in place or robust enough to ensure staff had the up to date knowledge and skills and supervisions to deliver effective care to people, according to their needs.

Regulation 18 (2) (a)

The enforcement action we took:

NoP for cancellation of registration reg 17