Leonard Cheshire Disability

St Michael's - Care Home with Nursing Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Michael's care home with physical disabilities is a nursing home providing personal and nursing care for up to 36 people. The service provides support to people with complex neurological and physical disabilities. At the time of our inspection there were 27 people using the service.
The building is a large period building, with a large communal dining area. There is a physiotherapy room on site.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence, and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people and providers must have regard to it.
Based on our review of the key questions safe, responsive and well-led, the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right Support:
The provider failed to have oversight of the quality of care and safety. The provider and registered manager had not ensured people received safe or good quality care. This put people's safety at risk and meant people did not receive a safe service.
The service did not always give people care and support in a safe, clean and well-maintained environment.
People were not always able to pursue their chosen interests and achieve their goals because of staffing shortages at the service. The home was reliant on agency staff that did not always know people well. Staff did not always communicate with people in a way that met their needs.
People had some choice over their living environment and rooms were somewhat personalised.
Staff supported people in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice

Right Care
People were not always protected from abuse or the risk of harm; not all staff had completed necessary training to meet the needs of the service user, staff did not always recognise risk of harm to people, staff did not always escalate concerns as required, audits and monitoring of the service did not always identify risk and reoccurring concerns. An effective system was not in place for reporting and reviewing accidents, incidents and near misses involving people.
People's medicines were not always safely managed, this meant people were at risk of receiving or not receiving medicines which may not meet their current needs.
Health and social care professionals were involved in the care and support of the people living in the home.

Right Culture
There were not enough staff and there was a reliance on agency staff to meet people's needs.
The provider and the manager had failed to implement a robust system to monitor the quality of the service. Improvement in areas of risk management had not been fully implemented in respect of the people's safety and cleanliness. The geographic location of the service was isolated, the home being on a main road. There was no access to public transport nearby. The service had a vehicle to take people to appointments and on trips.

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

Rating at last inspection
The last rating for this service was outstanding (published 6 November 2019)

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

The overall rating for the service has changed from Outstanding 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 St Michael's on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, person centred care, safeguarding, safe staffing and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe	**Inadequate**
Is the service responsive? The service was not always responsive	**Requires Improvement**
Is the service well-led? The service was not well led	**Inadequate**

St Michael's - Care Home with Nursing Physical Disabilities

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 team consisted of 3 inspectors and an Expert by Experience who carried out calls remotely with relatives. 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
St Michael's 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. St Michael's is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this

location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

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

During the inspection
We spoke with 4 people and 8 relatives about their experience of care. We spoke with 9 staff including the registered manager.

We reviewed a range of records. This included 8 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment and several agency profiles. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We continued to seek clarification from the provider to validate evidence found following the inspection. We looked at training data and quality assurance records. We requested feedback from several professionals involved with 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 good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Lessons learnt when things go wrong

- There was inadequate analysis of accidents, incidents and near misses to reduce the risk to people. A review of records showed incidents had not always been reported and reviewed to facilitate learning and a review of the management of risk. Where the provider had identified people were at risk of harm, they had not always acted to mitigate the risks to people. This meant the provider had not always learnt from previous incidents and put measures in place to mitigate the risk to people.
- We identified reoccurring incidents with people who had their nutrition through a PEG (percutaneous endoscopic gastrostomy) feeding tube. People who received their nutritional intake via a PEG feeding tube had plans in place informing staff how to administer people's feeding regimes, including the position people needed to be in during and after the procedure. However, these plans were not always followed. There was contradictory guidance in people's care plans and on their repositioning charts for staff to follow for repositioning people who had their nutrition through a PEG.
- Communication between staff including senior staff members was not always effective at sharing information that could prevent harm to a person. For example, one person's adaptor on their feeding machine had broken, this information had not been shared from day to night staff. This meant there was problems with the person getting their feed and medication at the right time. There had been three other incidents of the person not getting their feed at the right time. On one occasion where this had happened this caused the person's blood sugars to drop putting them at risk of hypoglycemia. An intervention was required whereby the nurse needed to administer pineapple juice through the person's PEG feeding tube in order to raise their blood sugars again to a safe level.
- There were a number of agency staff working at the service. Agency care staff did not have specific skills to support people. This meant there were people working at the service who had not been trained in specific conditions such as diabetes and PEG feeding. Incidents occurred involving agency staff putting people at risk, agency staff were not always included in any identified lessons learnt following the incidents. This meant agency staff where there had been concerns with their practice continued to work with people at the service without their practice being addressed. We identified incidents where agency staff had not followed people's PEG feeding positioning guidance resulting in a person becoming unwell. The concerns were not discussed with the agency staff and they continued to work at the service supporting people with positioning during PEG feeding.
- The service had recently reviewed the process of PEG feeds and had made changes to how feeds were stored in order to improve safety. The registered manager told us she was trying to arrange additional training around PEG feeding and positioning for staff and updating competencies in relation to PEG feeding. This had not happened at the time of the inspection.
- Training records showed some staff were not up to date with specific training such as medication administration including PEG feed medication administration, choking, manual handling and safeguarding

courses. Although outstanding training had been identified by the registered manager there was no plan for when the training would happen. This was relevant because there had been a number of safeguarding concerns involving care being given by staff.

● There were people living at the service with diabetes, the provider did not provide diabetes training for its care staff. This meant people were not always supported by staff who had been trained in conditions that the people lived with and therefore could not identify signs or risk to their health of a person becoming unwell.

● We received mixed feedback from relatives about people's safety. One relative told us, "The room my relative was first in was unsafe for them as the buzzers did not work. Once my relative had been sick for hours and was sitting in their own vomit unchecked by staff. So, no I do not feel that my relative is safe here." Another relative told us "There is a high turn over of staff which isn't helping people to get to know my relative or the other people here. I do think that the staff are attentive to my relative which reassures me that they are safe here."

● Some people had been assessed as being at risk of malnutrition or dehydration and were having their food and fluid intake monitored. Records in relation to food and drink were of a poor quality and did not always show that people had enough to eat and drink. For example, fluid charts did not always inform staff of any target intake. Although there was a box asking staff to indicate if the person had met their target or not, this had not been completed by staff on all the charts we looked at. This meant it was difficult to assess if staff had noted that people had not drunk enough, or if they had escalated their concerns. When we asked staff what people's target fluid intake was, they were unsure and gave mixed responses.

● Food intake charts did not always describe what people had eaten. Although some charts contained detailed information, not all did. Entries on charts included, "Yoghurt" and "meal." When people had not eaten all their meal, there was limited information. This meant it was difficult to assess whether people had eaten a nutritionally balanced diet and which parts of the meal they had eaten. The registered manager showed us new food and fluid charts that were soon to be introduced in order to address the issues we noted.

● We observed call bells ringing often during the inspection, we were told there was a fault with the system which meant they rang when people did not always need support. However this meant that staff could not always identify who really needed support and when, increasing risk of harm to people. Recent call bell audits had been completed in January and February 2023, these showed call bells were not always answered in a timely manner.

The provider failed to manage, assess, and mitigate risks to people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people had been assessed as being at risk of pressure sores. Care plans detailed any pressure relieving equipment in place and informed staff how often they should support people to change their position. All the air mattresses we looked at were set correctly.

● Regular health and safety, and environmental checks and audits were carried out to monitor the safety of the service.

● Emergency plans and individual fire evacuation plans were in place to ensure staff could support people in the event of a fire or other emergency.

Systems and processes to safeguard people from the risk of abuse

● Safeguarding incidents were not always identified and reported to keep people safe from harm. On inspection we identified incidents involving people which had not been reported to the local authority safeguarding team, who were responsible for investigating concerns of abuse. This meant measures could not be put in place to safeguard people and help prevent incidents from happening again. One safeguarding

concern that occurred on 14 February 2023 was not reported to the local authority until 27 February 2023. On 25 February 2023 a further safeguarding incident happened involving the same agency member of staff.
● Although staff told us they knew how to recognise and report abuse, we found evidence of another safeguarding incident that was not escalated to the managers.

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.

● Staff we spoke with told us they knew how to report concerns about poor care. Comments included, "Any concerns about poor care, I would report to the nurse or [Registered manager]. I'm confident they would action it. If they didn't I would speak up and go higher" and, "I would speak up, I would not stand for anything. I'm big on dignity and respect."

Staffing and recruitment
● A staffing dependency tool was in place to assess staffing levels in line with people's support needs. However, we were not assured there were enough staff on duty to meet people's needs. All the staff we spoke with said they did not feel they were able to fully meet people's needs because of staff shortages. Comments included, "There are not enough staff, it's very stressful sometimes. They [staff] are running around. Care staff get upset because there is just too much to do." "There are enough [staff] today, but not usually. It feels stressful" and, "It's the bare minimum number of staff."
● Staff told us that when there was not enough staff on duty, there was an impact on how they could support people. Staff told us that when they were short staffed that people did not get offered a shower for example. Comments included, "If there are not enough staff in, it means people have less of our time, such as how many people we can support. For example, people not showering" and "We can't shower people because we don't have enough staff. A bed bath is quicker and easier." Daily Team Leader monitoring records for 06 March 2023 confirmed this because staff had documented, "(person) only due to staffing" and on 04 March 2023, there were no showers recorded.
● As well as the impact on people's personal hygiene needs, staff said they felt staff shortages impacted on other aspects of care. Comments included, "The lack of staff has impacted on the people that live here. People like to have a chat, and when I go around [the building], I will always make people a drink and have a chat with them. With Covid as well, it's been hard and sad for people."
● The service used agency staff 24/7 on a regular basis. During the inspection we identified agency staff were not completing an induction into the service as part of working there. The was relevant because there were repeated incidents that put people at risk of harm involving agency staff. Agency staff supporting people were not aware of people's needs and how best to support them.
● Agency staff who were working at the service regularly were not included in service training or provided with supervision. This is relevant because of the number of incidents involving agency staff happening at the service. There is no mandatory requirement for providers to offer agency staff training and supervision. However, by not including agency staff who worked regularly at the service in training and supervision, there was a lack of manager oversight and where people had been at risk of harm, any learning from the incident was not always shared with agency staff.
● The registered manager told us they carried out competency checks on permanent staff. They told us Leonard Cheshire nursing staff were required to complete a competency self-assessment. At the time of the inspection only 2 permanent nursing staff out of 4 had done this. We asked the register manager to follow this up.

The provider had failed to ensure sufficient numbers of suitably qualified staff were deployed across the service. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Staff told us that despite low staff numbers, they supported each other. One staff member said, "It's really enjoyable getting to know the residents and working with staff who support you, but it would be better if it wasn't so busy."

Medicines were not always managed safely.
● The process for maintaining stock balances of prescribed medicines was not robust, which meant that people did not always receive their medicines as prescribed because there were none in stock. On the first day of the inspection, we observed parts of 2 medicine rounds and saw that 2 people's medicines were out of stock. One of these was a dietary supplement and there had been none in stock for 6 days which meant the person had missed 11 doses. Staff had chased the local pharmacy and surgery, and this was recorded, but the prescribed supplements had not been delivered. The registered manager told us they were trying to improve the process by meeting with the pharmacy and GP surgery to resolve the issues, but this meeting had not been booked at the time of the inspection.
● The service used homely remedies alongside prescribed medicines. Homely remedies are medicines that can be bought over the counter without a prescription. Records in relation to homely medicines were inconsistent. For example, the stock balance of Paracetamol was 2 tablets, but the tablets were not in the homely remedies cupboard and could not be located. There were 60 laxative tablets in stock, but no record of any stock had been recorded.
● Some people had been prescribed transdermal medicines, but transdermal patch records were not consistently in place. Some of the transdermal patches prescribed needed to be rotated at each application and should not be reapplied in the same place for 3 weeks. Because there were no records in place it meant staff would not be able to assess if they were applying new patches in the correct location or whether they were following manufacturer guidance. The nurse in charge addressed this during the inspection.
● Records in relation to topical medicines such as creams and lotions were inconsistent. Instructions for staff on where and when to apply creams was available in some people's rooms but not always. We asked staff how they knew where to apply creams. One staff member said, "I think something new [documentation] is coming in but I would ask the nurse or ask people themselves. I'm not sure if there is creams paperwork in people's folders."
●Tubes of creams and lotions had not always been dated when opened which meant staff would not know when the contents had expired.

The provider had failed to ensure medicines were consistently managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were administered by staff who had their competencies assessed. Staff did not rush people, made sure they had a drink and asked if people needed any pain relief.
● Medicines were stored safely and when no longer required, were disposed of safely.
● Protocols for additional medicines people might require (PRN) were in place. The registered manager was in the process of updating these to make them more personalised. When additional medicines were administered, staff documented the reasons why and the outcome.

Preventing and controlling infection
● The environment was not always visibly clean. Some people had bed rail covers on their beds which were marked, and some were ripped. We showed these to the registered manager, and they had been cleaned by day 2 of the inspection and replacement covers ordered.

● Some bedroom furniture was worn or chipped. This meant effective cleaning was not possible. Some areas of bedroom carpets did not look visibly clean. Door frames were damaged, and the wood was chipped and worn. Some of the walls were damaged.
● Some areas were dusty and there were cobwebs in some windows. The providers policy on 'Safe management of the care environment' was not always being followed.
● There were records of high touch point cleaning in place, these did not detail which touch points needed to be cleaned or specify the frequency other than, "am" and "pm". There were gaps in some of the records.
● Although there were cleaning schedules in place, these had not been signed every day. Staff informed us people's bedrooms were cleaned by housekeeping staff on a weekly basis and that care staff were responsible keeping bedrooms clean in between. One staff member said, "I try to prioritise, and get things done that have to be done. We've got one staff who tested positive so [staff name] covers all the touch point cleaning to make sure we keep people safe. We've got lots to contend with here, lots of bugs and people coming in and out of hospital" and, "We can't physically clean every room every day. We will empty bins etcetera if we see them full. I will see things as I go, and clean what I can as I see."
● Cleaning records in relation to communal areas had not been completed every day. For example, records showed that on 05 March 2023, the servery area and dining room were not cleaned.
● The cleaning schedule referred to tasks for "Domestic A" and "Domestic B." However, we were informed that on occasion, there was only 1 member of the team on duty. On day 2 of our inspection there was one staff member covering the laundry and one staff member responsible for cleaning.
● On the first day of the inspection we were informed a staff member had tested positive for Covid-19 and the service had re-introduced face masks and testing for staff and people using the service.
● On day two of the inspection, despite a notice informing staff of the need to carry out a lateral flow test before their shift began, not all staff we spoke with were aware of this. We informed the registered manager and they addressed this with staff during the inspection.
● There was a cupboard which was used to store PPE. Some of the boxes were open and items were exposed. The cupboard was in a poor state of repair and because of this there was a risk that items could become contaminated and not be safe for use. We showed this to the registered manager who said the room should only be used for storage of closed boxes. However, it appeared that not all staff were aware of this.

The provider had failed to ensure systems were in place to protect people from the risk of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were somewhat assured that the provider was admitting people safely to the service. There had not been any new admissions to the service.
● We were assured that the provider's infection prevention and control policy was up to date.
● There was enough personal protective equipment (PPE) available. Staff had been trained in infection prevention and control and knew when to wear PPE and when to change it. Regular handwashing audits and spot checks of staff were carried out.

Visiting in care homes
● At the time of inspection the provider was following government guidance.

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

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Requires Improvement

Is the service responsive?

Our findings

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

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● People had individual care plans; we found the quality of the care plans was mixed. Two people's care plans we viewed contained contradicting information to an assessment that had been completed by a health professional.
● Daily notes completed for people were not person centred, notes we reviewed gave basic information such as 'pad change' and 'assisted with lunch'. There was no information on how staff were engaging with people throughout the day.
● Care plans documented people's preference for male or female carers. However, 2 people we spoke with told us that their relatives were being cared for by male carer's often when the person had asked for female carers to provide personal care.
● People we spoke with told us that they spent a lot of time in their rooms. This was in contrast to what care plans said people wanted to do. One person told us they had to sometimes get up when the staff wanted.
● Staff told us people were on a rota for a shower with set days, from the care plans we viewed there was no evidence of this being people's preference. This impacted on people's hygiene, dignity and people's choice.

This was a breach of Regulation 9 (person centred care) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was mixed feedback from people about how they were cared for. One person told us agency staff did not ask the person's name or engage in conversation when caring for the person. Another person told us the "Care was amazing at St Michael's."
● There were one-page profiles in place in care plans to provide staff with an overview of people's preferences. There were sections on "What is important to me, things people admire and like about me and things you need to know or do to support me."
● There were examples of some areas of the plans were personalised, for example, some plans around personal care described in detail what people liked to wear and if they preferred to get up early in the morning. People and their relatives had been involved in their care plan reviews. Some plans in relation to people's health needs were detailed and provided clear information for staff.
● We asked staff how they learnt about people's choices and preferences for how they wanted to be supported. Staff told us they had access to the care plans but did not have time to read them. One staff member said, "I read the handover sheet and try to read the care plans but it's really busy. I find out about people from other staff telling me and from people themselves."
● People's protected characteristics under the Equality Act 2010 were identified in their care plan and respected. This included people's religion, culture and sexuality.

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.

● Care plans we viewed had mixed information about people's communication needs. For example, there was reference to a person using Makaton to aid with communication. Makaton is a communication tool together with speech and symbols, to enable people with disabilities or learning disabilities to communicate. However, this did not say how the person used Makaton to express their needs or wishes. One care plan said the person 'communicates through body language, they enjoy all aspects of sensory activity and intensive interaction activity'. One staff member told us they had not heard of intensive interaction. There was no evidence in the persons care plan and daily notes of sensory activity or intensive interaction.

This was a breach of Regulation 9 (person centred care) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● There was a lack of meaningful activities for people to do. People told us they could not do the things they enjoyed. One person told us they spent a lot of time in bed. Another person told us they did not offer the type of activities they liked to do such as boardgames. One staff member told us people wanted to go 'banger racing' or to the local car boot sale but it had been difficult to facilitate this.
● On day 1 we observed 1 person in bed all day watching children's programmes on their television. The care plan did not say the person enjoyed watching this type of programme. On day 2 the same person was sat in the dining area on their own. We did not observe staff interaction with the person other than at mealtimes.
● We saw the activity planner for the week which said on most days there were no activities. We were told this was because the activities lead was on annual leave. There was a part time activities co-ordinator working during the inspection who was supporting some people in the dining area some of the time. There were a number of people in their rooms. One person told us they preferred to be in their room as the dining room was cold.

This was a breach of Regulation 9 (person centred care) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was evidence of events and outings some people had attended over the past month. However people's experiences were not recorded in the care plans or daily notes we viewed. The service is developing individual folders for people where their experiences from activities and days out can be recorded.
● The service was in the process of developing a sensory room, we saw evidence of work being carried out during the inspection. The registered manager told us of the plans to create an activities room on the same floor as people's rooms and the dining area.
● There was a chapel onsite, some people attended this daily. We observed 1 person spending time in there during the inspection.

Improving care quality in response to complaints or concerns
● Verbal concerns and complaints were not always logged. This meant that actions were not taken or communicated to the staff team. We saw evidence of 2 complaints that were logged over the past 12

months. Whilst the registered manager had responded to the complaints, records we saw did not demonstrate how the complaint had been investigated or evidenced any actions taken. The registered manager told us that people and relatives raised things informally and did not always want things raised formally.

● We saw 1 complaint raised by a person living at the service against a staff member recorded on an incident form and left in the accident and incident folder. This meant that the confidentiality of the person and the staff member was compromised.

End of life care and support

● The service had accessed support from a charity to support people to talk and plan for their end of life care. The charity and trusts local to the service were working in partnership on this project to encourage and support people to have important conversations about death and dying. Having this information in place meant staff would have the information they needed in order to support people at the end of their lives in the way they wanted.

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 outstanding. At this inspection the rating has changed to inadequate.

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

- The provider failed to implement systems and use them effectively, to monitor and improve the quality and safety of care provision in the service. There was no clear oversight from the provider and the provider did not visit the service regularly. The last provider visit to the service was in September 2022.
- There was a service improvement plan and it had not been updated since October 2022. The registered manager updated the service improvement plan during the inspection.
- The registered manager carried out some audits and quality assurance checks of the service. However quality assurance checks were being completed on a rolling basis meaning some checks were not being carried out regularly enough where concerns had been identified. The quality assurance checks being completed were ineffective in identifying the concerns we found during inspection.
- Accidents and incidents were not analysed effectively for patterns or trends and to ensure actions taken were effective. Potential safeguarding concerns were not always identified and escalated, as a result further avoidable incidents occurred.
- Staff were not always suitably trained and their competencies were not checked due to an ineffective quality assurance process. As a result people were put at unnecessary risk of unsafe and poor care.
- Communication between staff including senior staff was not always effective and put people at risk of harm. Some records were poorly maintained and organised including agency profiles, accident and incidents and staff handover records. This meant that there was inaccurate information held in the files and information pertinent for an audit trail was missing. Quality assurance processes had failed to identify these shortfalls in a timely manner.
- People were at increased risk from the spread of infection because infection prevention and control measures were not always implemented.
- There was limited provision for people to participate in meaningful activity and occupation.
- Daily notes lacked detail and were not reflective of person-centred care.
- The agency profile folder held details of people from agency's the provider no longer worked with. We identified a number of agency profiles where the person's right to work permit had expired. We raised this with the registered manager at the time who told us they would review all the information in the agency profile folder. We will ask for assurances this has been done as part of our reviewing processes of the service.

The provider did not have effective systems to assess, monitor and improve the service provided. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Statutory notifications were not always being completed and submitted to the CQC following safeguarding concerns. Statutory notifications are important because they inform us about notifiable events and help us to monitor the services we regulate.

This was a breach of regulation 18 (Notification of other incidents) of the Health and Social Care Act 2008 (Registration) Regulations 2009.

● The service was in the process of making some improvements to the lay out of the building to make it more accessible for people.

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 registered manager understood the duty of candour legislation, which is to be open and honest when something went wrong

Continuous learning and improving care
● We were not assured staff had been trained to support people appropriately who had specific needs. The provider offers Learning Disability and Autism training as part of their staff induction. We viewed training records dated 28 March 2023, these records showed 31 staff had undertaken learning disability tier 1 training, 5 members of staff completed the training over 3 years ago. We did not see evidence of staff receiving any further learning disability training since their induction. We did not see evidence of care staff completing autism training. This is of relevance because the service supports people with a learning disability and autism. Permanent staff and agency care staff working at the home did not always have the necessary training to meet the needs of the people who live there. Mandatory training had not been completed and this included 16 staff members who had not received their safeguarding training.
● Despite there being a number of safeguarding concerns involving care provided by staff, the provider had not taken action to ensure its staff training was identified as a priority. Therefore, we were not assured that continuous learning to improve care was taking place.
● The registered manager told us that through service level quality audits they had identified there had been a number of unplanned hospital admissions. The registered manager told us they had regular remote meetings with the providers clinical lead for the area, the service was introducing some forms to support staff in monitoring people who may be at risk of malnutrition.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We received mixed feedback about how the service was led and managed. One relative told us "My relative was told that they would be able to mobilise themselves into the nearest village/town but the driveway here is very steep and the road at the bottom is very busy and so that is a health and safety risk." Another relative told us "If any activities are booked weeks in advance, you can bet it will be cancelled on the day as there are not enough staff available. Which is so sad for the people living here." Another relative told us their relative came for respite and decided following their stay they would like to live there permanently.
● Staff culture was not always positive, a number of permanent staff had left the service over the past 12 months increasing the reliance on agency staff. Staff told us they could not always meet people's needs because the service was understaffed. However, staff said that despite how they felt about staffing levels, they enjoyed their roles. They said morale was, "Variable" and, "Sometimes it can be tough, but we don't have time to stress, we're so busy we don't have time to moan. We have a good team spirit here. We help each other" and, "We try and stay positive around residents, but it's a strain."

● Regular staff meetings were planned. Staff said if they were unable to attend for any reason, the minutes were provided for staff to read in their own time. Staff said they felt able to speak up during meetings. Comments included, "We are encouraged to speak up in the meetings and I do feel OK to bring things up." There were team building days booked for all staff to attend.

● There was a provider newsletter to inform staff of any news and updates between meetings.

● Staff said they felt supported in their roles. They spoke highly of the registered manager. Comments included, "She [registered manager] is very good, she listens. She will roll her sleeves up and muck in and, "The management team are supportive. They're in the building and will make time if they're needed."

● The registered manager had arranged staff team building days for the near future.

●The service was including people in the process of recruiting new staff, at the time of the inspection one person had agreed to be part of the interview process for new staff.

● Local voluntary and community services supported at the service, for example the local Rotary club helped to run a bar for people on a regular basis.

Working in partnership with others

● The service worked in partnership with services, such as a range of multi-disciplinary health professionals. We saw evidence in some care plans of the involvement of Speech and Language Therapists (SALT) and mental health professionals. The registered manager told us that health professionals were regularly involved in decisions about people's care.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager did not always submit statutory notifications following safeguarding concerns. This was a breach of regulation 18 (Notification of other incidents) of the Health and Social Care Act 2008 (Registration) Regulations 2009

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure people received person centred care This was a breach of regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure people were protected from abuse and neglect. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to ensure sufficient numbers of suitably qualified staff were deployed across the service. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to manage and assess potential risks to people. The provider had failed to ensure medicines were consistently managed safely. The provider had failed to ensure systems were in place to protect people from the risk of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to monitor the safety and quality of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

warning notice