Supported Living UK Limited

Foxhills Farm

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Foxhills Farm is a residential care home providing personal care to up to 5 people. The service provides support to people who live with learning disabilities and complex needs. At the time of our inspection there were 4 people using the service in one adapted building. The home has two floors
accessed via stairs, communal areas and large garden.

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.

Based on our review of key questions safe, effective and well-led, the provider was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right Support: 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.

Right Care: People were at risk of harm because staff did not always have the information, they needed to support people safely. Medicines were not managed safely. People did not receive consistent person-centred care that was empowering, of a high-quality and achieved good outcomes. The service was not located so people could participate in the local community. The service was close to a busy road, with no pavements, the nearest bus stop was over half a mile away along this road and there was no access to local shops, the closest place being a garden centre. The lack of drivers at the service meant people were not supported to access their local community as often as they would like. People had privacy for themselves and their visitors in their bedrooms.

Right Culture: Ethos, values, attitudes and behaviours of leaders and care staff did not fully ensure people using services led confident, inclusive and empowered lives.

Assessing risk to the health, safety and wellbeing of people, medicines management and infection prevention and control were not managed safely.

Recruitment was not always managed safely to support the recruitment of suitable staff. Staff who were employed did not always have the relevant training to enable them to do their job.

The service was not maximising people's choices, control or independence. There was a lack of person-

centred care and people's human rights were not always upheld. There was a lack of timely action by leaders to ensure the service was well staffed and safeguarding incidents were responded to. This meant people did not lead inclusive or empowered lives.

People were not being offered a wide variety of food and vegetables. We have made a recommendation about this.

People's personal identifiable information was not always stored securely, we have made a recommendation about this.

Leadership was poor, and the service was not always well-led. Governance systems were ineffective and did not identify the risks to the health, safety and well-being of people or actions for continuous improvements. Where improvements had been identified, these had not been fully achieved Records were not always complete. People and stakeholders were not always given the opportunity to feedback about care or the wider service. This meant people did not always receive high-quality care.

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 good (published 31 October 2018).

Why we inspected
We received concerns in relation to staffing levels, physical intervention training, waste management, lack of supervision, lack of person-centred care, staff shouting at people, and the lack of the managers presence in the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only, during the inspection we made the decision to look at the effective question as well.

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

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

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

Enforcement and Recommendations
We have identified breaches in relation to risk management, recruitment, safeguarding, the mental capacity act, staff training, person centred care, governance, duty of candour and failure to notify CQC of significant events at this inspection.

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

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.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This

means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Foxhills Farm

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by 2 inspectors.

Service and service type
Foxhills Farm 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. Foxhills Farm is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was not a registered manager in post. A new manager had been in post for approximately 6 months and had applied to register as the registered manager. We are currently assessing this application.

Notice of inspection

This inspection was unannounced. Inspection activity started on 17 January 2023 and ended on 2 February 2023. We visited the location's service on 17, 18 and 23 January 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. 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 2 people who used the service and received email feedback from 2 relatives about their experience of the care provided. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed. We spoke with 8 members of staff including the nominated individual, the managing director, the manager, 3 care workers and 2 agency workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We received email feedback from 2 professionals who work with people who lived in the home.

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

- The provider had failed to ensure the safety of people. Risks to people were not managed and mitigated effectively.
- Although some robust risk assessments were in place, other risk assessments did not contain enough information to guide staff on how to mitigate and manage the risks relating to people's needs. This meant we could not be assured people's needs were appropriately managed.
- For example, one person had a support plan in place to guide staff how to manage behaviours. It listed physical interventions in place to support the person however, there was no detail about how to complete a specific intervention and only one staff member was trained in this intervention. There was no guidance on what to do when no available staff were trained. This meant people and staff were at risk of harm.
- One person had an eating and drinking risk assessment in place, it stated they were not at risk of malnutrition based on an assessment and their weight in 2019. The support plan dated 7 January 2023 had not been reviewed or updated since this time. The information in the plan was therefore 4 years old, this also applied to other support plans for this person. This meant there was risk staff were not supporting them in line with their current needs and up to date information.
- We observed 1 person eating lunch which consisted of sausages cut into large chunks with 3 chocolate brioche buns. This person put several large pieces of sausages into their mouth at once. However, their eating and drinking risk assessment stated, "Staff to ensure [persons] food is cut up into several bitesize pieces." An agency staff member came to watch and stood in the doorway when the person had nearly finished all their sausages. Due to the size of the sausage chunks and the persons inability to cut food up further and eating several pieces at once, this person was at risk of choking. While there was a risk assessment in place staff failed to follow it.
- Another person had sandwiches cut into small bitesize pieces and whole grapes. They put multiple pieces of food in their mouth at a time. There eating and drinking support plan stated, "[Person] can overload their mouth and therefore needs supervising in case they choke." However, there were no staff present in the conservatory where people were eating. A staff member told us they watch from the kitchen however, no one came to support this person when they were overloading their mouth. This meant this person was at risk of choking and although there was a risk assessment in place staff failed to follow it.
- We saw 1 person had a medical conditions risk assessment which covered Epilepsy. There was no detail in this risk assessment about how long seizures may last or when staff should phone for medical intervention if for example, the seizure lasted a long time. This meant the person was at risk of staff not knowing how to manage a seizure, especially because the provider used agency staff to cover most of their shifts.
- One person was prescribed a medicine to use in the event of a seizure lasting longer than 5 minutes. The support plans stated, 'We are awaiting Epilepsy Consultant verification before we administer this. It's 999 at this point in time.' However, this plan was implemented on 7 April 2022 and had not been updated or

reviewed to say if the consultant had responded in the last 9 months. There was a risk this person's medicine would not be administered because staff may not know if it had been approved or not, this put this person at risk of harm.

● Peoples weights were looked at monthly however, only the current month and the previous months weights were visible. One person looked small and frail. It was not possible for us to assess if this person had lost weight, maintained weight or put any weight on over a specific period due to the lack of available records. We asked to see some people's weight charts for the last year. The manager said the weights were available on the monthly review charts. We asked for this information to be sent to us however, this was not received. We were not assured the provider assessed the risks involved with people's nutritional needs.

● One person's personal emergency evacuation plan (PEEP) was dated 5 January 2021 and had another person's name on it. The PEEP guided staff to pick up the grab bag on the way out of the building, however, it did not specify where grab bags were kept. Grab bags usually contain essential information and items a person may need in the event of an evacuation. New or unfamiliar staff may not know where these bags were kept which meant they may not have access to essential information in the event of having to leave the building overnight.

●A boiler cupboard containing a boiler with hot pipes was not locked. This meant people were at risk of burns if they accessed this cupboard. The manager said they would put a lock on it. There was no risk assessment in place to identify the risks of having an unlocked boiler cupboard which was accessible to people.

● We observed a cupboard under the sink in the kitchen which was labelled, 'Chemical store, keep door locked shut and no entry to unauthorised persons.' This cupboard was unlocked and contained cleaning liquids and dishwasher salt. The manager told us, "It should be locked." There were risks people could be harmed if they accessed this cupboard and its contents. The labels suggested the risks had been considered however, staff failed to ensure the safety notices were adhered to.

The failure to ensure people were provided with safe care and treatment and risks were assessed, monitored and mitigated was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Recruitment practices were not robust, and staff were not always recruited safely.

● For example, gaps in the employment history of staff were not always followed up to ensure there was a satisfactory written explanation for this. This meant the provider was not always able to consider whether the applicant's background impacted on their suitability to work with people who were vulnerable.

● References were not always received for staff, when this occurred there was a risk assessment in place. However, this had not been completed to describe what mitigation would be in place to reduce the risk of employing unsuitable staff.

● When reviewing recruitment paperwork, where concerns were raised that required the provider to put a risk assessment in place. The new starter risk assessment did not identify what had been in put in place to reduce the risk to people when employing such staff. We spoke to the manager and provider about this who told us this was managed by their recruitment department and they did not have anything to do with this.

The failure to establish and operate recruitment procedures effectively was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● All staff had a DBS check in place. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

● Medicines were not always managed safely. Not all people who were prescribed 'as required' (PRN) medicines had a PRN protocol in place to guide staff when and how to use these medicines. For example, one person was prescribed a variable dose of their medicine however, there was no guidance for staff to say how much should be given and why. This meant they were at risk of receiving the wrong dose of medicines for their needs.

● Medication risk assessments stated, "Medication is to be counted on a daily basis and cross referenced to ensure correct medication and dosage has been administered." However, a staff member told us this wasn't done daily due to staffing levels and said, "We do it when we can." The risk assessment had an implementation date of 7 January 2023, it was unsigned however, both the manager and the provider knew the current staffing levels were poor. There was nothing in place to monitor the risks when staff were unable to complete a daily count of medicines.

● Staff were administering two different injections to one person. One was prescribed once a week and the other was prescribed once every two weeks. MAR chart records showed the weekly injection was administered with gaps of 6 days on one occasion and gaps of 8 days on two occasions. This meant this medicine was not being administered as prescribed. The injection prescribed every 2 weeks was administered once on 30 December 2022 and again on 10 January 2023 which was a gap of 11 days. This meant the medicine was administered before it was due and put the person at risk of harm. Staff had been trained to administer these injections by a nurse employed by the provider. However, there were no competency assessments in place to check staff were administering these medicines correctly in practice.

● Topical creams were not managed safely, and Medicines Administration Records (MAR) charts were not always signed to evidence if they had been administered. This meant there was a risk people were not having their topical creams administered as prescribed.

● One person was prescribed an ointment as a moisturiser and soap substitute to be used, "At least 4 times daily." There was only one staff signature on the MAR chart on 7 January 2023. This meant this person was at risk of their skin becoming dry and breaking down. We spoke with a senior carer about this. They told us it had only been prescribed at least 4 times a day when they changed pharmacy. However, no one had contacted the pharmacy or GP to discuss this change.

● One person's PRN protocol contained the name of two different medicines. The protocol was about a medication to reduce agitation however, in the actions to take post administration column it stated, "Write up the effects of the paracetamol on the back of the MAR" which is for pain relief. This was confusing for staff.

● Medicines are required to be stored at certain temperatures to ensure they remain effective. Medicines temperature recording was not done consistently for medicines kept in the medicines cupboard and were not done at all for medicines kept in the medicine's fridge. There was a risk medicines could become ineffective if they were being stored at the wrong temperature.

The failure to have the proper and safe use of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

● Infection prevention and control was not managed safely. We were not confident the practice in the service was in line with their policy, people were not always protected from risks of infection.

● The providers infection prevention and control policy was dated October 2020 with a review date of October 2022 however, it had not been reviewed in October 2022. The policy contained outdated information, stating all care staff should wear surgical face masks when delivering personal care, or within close proximity (2 meters) of an individual using the service. This was in line with guidance dated September 2020. The policy had not been updated at the height of COVID-19 when mask wearing was recommended all

the time in care homes. There was a risk the correct guidance was not being followed. Following the inspection, the provider told us, "We wanted to assure that we have been circulating the most recent guidance regularly regarding COVID-19, this has been within our internal communications and weekly meetings with our managers." A summary document detailing where to go for up to date guidance was shared by the provider.

● There were 2 refuse bins at the entrance to the drive that had rubbish bags which were split and piled high to overflowing. Rubbish was all over the ground surrounding the bins. In the front drive there was a large open skip containing rubbish bags some of which were split open, there was rubbish on the ground surrounding the skip. We spoke to the manager about this who told us they had not had a company to collect refuse for several months and were trying to arrange an alternative company. There was a risk vermin would be attracted to the large amount of refuse which put people at risk of infection and disease.

● Fridge and freezer temperatures were not being taken. This is important to ensure food is being stored at the correct temperature and to reduce the risk of food poisoning.

● One of the fridges we looked in contained out of date salad. Another fridge contained foods that were opened and not wrapped and foods that did not have opening and discard dates recorded on them. This is important to prevent the risk of food going out of date and to reduce the risk of people becoming ill.

● The first aid box in the kitchen contained bandages that had gone out of date the month before the inspection. We reviewed first aid box checks, the last one was completed on 2 August 2022. The manager told us they struggled to complete a lot of tasks within the service due to a lack of staff. They told us they spent most of their time firefighting and covering rota's.

The failure to assess the risk of and prevent and control the risk of the spread of infection was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager was responsive to some of our concerns. On the second site visit the rubbish had been removed from on top of the bins at the end of the driveway and rubbish scattered around on the ground had been placed in the skip.

● Following the inspection, the manager told us they had secured a refuse collection company through the local council.

● On the second site visit the manager had introduced fridge and freezer temperatures in the service and these were still being completed when we checked on the third site visit.

Visiting in care homes

People told us they had visitors who came to the service. The manager told us visitors were welcome and some family members came regularly to take people out. Visiting was managed in line with current guidance.

Systems and processes to safeguard people from the risk of abuse

● Systems and processes in place to safeguard people from abuse were not effective.

● Some practices in the service were not assessed, this placed people at risk of institutional abuse.

● All people who lived in the house were checked every hour throughout the night. We asked the manager why people were checked hourly and they told us it was because they had a duty of care. However, there was no rationale for entering people's bedrooms every hour through the night, there was no detailed documentation as to why this practice was in place. After further discussion with the manager they identified they had put this in place for everyone after a person who had a Deprivation of Liberty Safeguards (DoLS) authorisation in place left the building on their own during the daytime. DoLS ensures people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty.

● On the second day of inspection the manager told us they had reduced the hourly checks for everyone and were now doing them at 10:30 pm and 6 am however, there was still no rationale in place for this and individual needs and circumstances had not been considered.
● Where safeguarding incidents had occurred, for example, people hitting each other or pinching each other a referral had not been made to the safeguarding team. Staff told us they would report any abuse to the manager however, the manager had failed to identify these incidents as safeguarding concerns. We spoke to the manager about this who told us she deemed these incidents as minor. This meant the local authority safeguarding team were not being kept informed of these incidents and were unable to monitor the service effectively.
● A relative told us one person had threatened to physically assault their family member and another person had pushed their family member on the stairs. There was no record of people being offered the opportunity to report these assaults to the police and no evidence of care plans and risk assessments being reviewed following these incidents.

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

● Staff had completed safeguarding e-learning and knew the signs of abuse to look out for.

Learning lessons when things go wrong
● When things went wrong, lessons were not always learnt to support improvement, and this was evident from our findings at this inspection. This meant the service did not demonstrate learning, reflective practice and improvement.
● Safeguarding events were not recognised and CQC had not always been notified. The registered manager was unable to demonstrate if accidents, incidents and safeguarding events were analysed to identify if any themes or trends were occurring. They told us the information was probably on their system, but they didn't know how to see this report. We could therefore not be assured if action would be taken to address any recurring patterns to promote and improve people's safety.

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 good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

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

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

- The provider was not working in line with the principles of the MCA.
- Where people lacked capacity to consent, mental capacity assessments had not always been completed for specific decisions and where capacity assessments had taken place there was not always a recorded best interest decision.
- The manager did not have a good understanding of the MCA. For example, we spoke with the manager about mental capacity assessments, the manager told us, "The nurse from the GP comes out and does assessments, I don't do it." During another conversation about mental capacity assessments the manager told us, "Mental health or social worker [do them]. We don't do capacity here." The manager had failed to understand it is the responsibility of everyone who makes decisions on behalf of others to recognise their role and responsibilities under the code of practice.
- As highlighted in the safe section of this report, some people living at the home were subject to restrictions upon their rights. Restrictive practices are when people are prevented from doing something usually in the form of restraint in order to keep them safe. The MCA had not been followed to ensure this practice was lawful.
- Most people living at the home were under continuous supervision and control. When this was discussed with the manager, they were unable to confirm if any of the people living at the home had conditions associated with their DoLS. One person did have conditions associated with their DoLS. This meant the DoLS was authorised under the condition any specified action was carried out. In this case a review of the

persons medication should be undertaken by the GP. The manager was not aware of the condition and had therefore not acted on it. This meant people's legal rights had not always been upheld.
● We spoke with the manager about DoLS authorisations, they said, "I am not sure how the authorisation thing works."
● We received feedback from a relative who told us, "I would welcome being involved in any mental capacity assessments and best interest meetings." However, they had not had the opportunity to be involved.
● Some family members managed people's finances. Not all people whose finances were managed by their families had Lasting Power of Attorney (LPA) documentation available. If you are unable to manage your own affairs, an LPA is legally appointed who is someone of your choice to do it for you. The manager told us they would check to see if they had this information on file. When we asked how the manager knew if people had an LPA, they told us, "Because families manage their finances." This response demonstrated the manager did not have a good understanding of the legal processes required to manage another person's finances for them.

Providing care and treatment without the consent of the person or in their best interests following mental capacity legislation was a breach of regulation 11 of the Health and Social Care Act 2008 (regulated Activities) regulations 2014 (Part 3).

Staff support: induction, training, skills and experience
● The provider's training records evidenced not all staff had not received adequate training in a timely way to equip them to carry out their roles safely and effectively. For example, some gaps were noted in the completion of fire safety training, health and safety training, diabetes training, equality and diversity training, nutrition and hydration training, oral health training, person centred care training and specific physical intervention training. Staff confirmed they had not received all the training they required.
● From our observations and conversations with some staff it was evident that although staff wanted to provide safe and effective care to people, they lacked the skills, knowledge and understanding of people's needs and how to safely and appropriately manage these needs.
● The manager told us 2 of the staff had only been there a few weeks and they had to complete the training within 6 months. The staff induction booklet stated, "It is important that all 5 mandatory courses are completed ahead of your first day in service… All additional e-learning courses will need to be completed withing 2 weeks of your start date." The manager did not understand the importance of staff being trained in a timely manner or the providers process.
● Only one staff member was trained in the providers specified physical intervention training. None of the agency staff were trained in the providers specified physical intervention training. Care plans and risk assessment mentioned specific physical interventions and accident and incident forms confirmed physical interventions were being used however, staff who had not been trained were taking part in using physical interventions with people which put people at risk or serious harm.
● There was a process in place for all new staff to complete an induction to the service and a period of shadowing experienced staff members before being permitted to work unsupervised. However, this was not always signed by the staff member. New staff started working with people prior to completing all their essential training and without having completed all their training by the end of the 12-week induction period.
● We asked the manager if the staff complete the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. The manager told us, "No, no one has mentioned anything to me about that. I think I did email, and no one replied." However, the induction booklet used by the provider states, "Firstly, to work in our support worker roles it's important to complete the Care Certificate in your first 12 weeks."

● Staff were being signed off as having completed the induction when the Care Certificate and training had not been completed. The induction did not align with the standards of the care certificate. The manager did not understand the importance of the care certificate if a suitable alternative induction was not in place.
● There was generally only ever one permanent staff member on duty with agency staff. There was a risk the permanent staff member was not adequately trained and may be relied on by agency staff. This meant people could be at risk of inappropriate care and treatment .

The failure to ensure staff received appropriate training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We received some positive comments form a relative about the care provided by the regular staff.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's needs were assessed before they moved into the home. Once this information was gathered, it was used to develop people's support plans and risk assessments with the support of people and their relatives. However, care plans and risk assessments were not regularly reviewed and updated when people's needs changed. This meant staff did not always have the information required to enable them to provide people with good person centred, safe and effective care.
● There were not enough staff to provide person centred care. On most shifts there was one permanent staff member on duty with 3 agency staff. Although the manager tried to use regular agency staff this was not always possible. People's support plan identified they wanted to be supported by people who knew them well however, this was not always possible which on occasions resulted in people becoming distressed and expressing a heightened state of anxiety.
● A staff member told us, "Staffing is biggest challenge. At least twice a week you're training someone new from the agency." We could not be assured staff training the agency had enough knowledge to do this.
● People were not able to go out as much as they wanted due to there being only one driver employed. The service was at least half a mile away from a bus stop and this was along a busy road with no pavements. One person told us, "I feel very isolated here, I can only go out twice a week."
● The manager told us one person goes out twice a week with staff and they try to ensure the driver takes other people out once a week. The manager had arranged for some family members to take people out due to the lack of drivers and permanent staff employed.
● There were games and activities available in the service and a large garden to the rear of the property however, one person told us, "They feed us children's snacks, they keep us occupied with children's activities and we watch children's programmes. I think I must have been put in a children's home." This meant the person's and possibly others, care and support was based on uninformed and discriminatory decisions.
● People had access to GP's, dentists and opticians, a lot of these appointments took place within the home. A GP called the service once a week to discuss people's health needs.
● On the third site visit, the staff member on duty informed us one person would not want to talk to us because they had not been feeling well for a few days and on the day of inspection had become confused and was staying in their room. The staff member told us they are not normally confused. We asked if the person had seen a GP and were informed by the staff member that they would probably phone in the morning to speak to a GP. Because the person had been confused all day, we asked the staff member to call the GP there and then which they did. This person was at risk of becoming seriously ill had the GP not been called in a timely manner.
● Food and snack cupboards were locked so people did not have direct access due to the assessed risks to

two people. This meant people who would usually be able to access their own snacks had to ask staff to open the cupboard. People who were unable to communicate when they wanted a snack would have to wait for three specified snack times. This meant due to some people's needs other people were restricted.

The failure to ensure people were provided with person-centred care was a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We could not be assured people were supported to eat a varied and nutritious diet. Evening meals were cooked by the staff and people were offered a choice of two meals; the second choice was geared towards one person. However, the choice between the meals was very similar on 4 out of the 7 days, on the week viewed both Monday meals were chicken based, Tuesday options were both fish based, Saturday options were both chicken based and on Sunday there was no choice.

● There was a lack of variety of meals with chicken being the only option on 2 days as well as being an option on a third day. On a fourth day turkey dinosaurs were an option. The vegetable options every day was mixed veg. This meant people were not being offered a wide variety of food and vegetables.

● One person told us they received small portions and staff eat the food, so the staff make sure there is enough left for themselves. We did speak to staff who were on duty during the inspection and they had brought their own meals in with them.

We recommend the provider seeks current guidance on menu planning and updates their practice accordingly.

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

● The service was not fully adapted, designed and decorated to meet people's needs. Some minor repairs were required, for example the edging had come off the kitchen work top exposing the chipboard. There was a risk of further damage to the work surface which may lead to an infection risk.

● Personal information was on display on the wall in the corridor, for example, two people's evening and bedtime routines were on the notice board. We asked the manager if it would be more appropriate for data protection and privacy reasons for this information to be kept in their bedroom or in the office. The manager told us it was on the wall for agency use and they probably wouldn't look at it in the office or if it was in the people's bedrooms. Aside from the data protection breach, this made the service feel less homely, especially because information on the walls was for the benefit of staff rather than for the benefit of the people living there.

● Half hourly resident check documents were on the wall outside people's bedrooms with their full name and a column which asked, 'what is the resident doing/any concerns?' This meant peoples personal information was on display for anyone in the building to see and was a breach of their data protection rights.

● The television in the lounge was leaning forward pointing at an angle towards the ground. We spoke with the manager about this. They told us the television had fallen forward, and they couldn't access it to push it back upright because it was in a Perspex case to protect it from damage. This made the television difficult to view comfortably. No action had been taken to arrange for this to be rectified.

● The service was and clean and tidy. Bedrooms were personalised to peoples taste and choices.

We recommend the provider seeks reputable guidance around the Data Protection Act and updates their practice accordingly.

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 good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The service was not well managed. Systems and processes were not operated effectively to ensure the service was safe and people were receiving high-quality care. This led to multiple breaches of regulation and placed people at risk of harm as outlined in the safe and effective domains of this report.
- It was evident the lack of staff impacted on the running of the service as described in the safe and effective sections of this report.
- There was a lack of robust governance processes and systems in place to help ensure the safe running of the service. Without these systems, the provider and management team could not be proactive in identifying issues and concerns in a timely way and acting on these. The concerns found at the inspection included but were not limited to, staffing, training, care records, risk management, consent and the mental capacity act, infection prevention and control, environment safety concerns and the lack of person-centred care.
- The provider failed to follow their own governance policy to ensure quality and safety. Some audits were carried out, but these were not done in line with their policy because they were not completed consistently or effectively and did not drive improvement.
- The manager told us audits had not been taking place previously, but they had started to complete some audits in December 2022. However, where they were in place, they were not effective and had failed to identify the concerns we found during the inspection.
- For example, the manager had identified on 11 November 2022 risk assessments and support plans for all people needed to be reviewed and updated to ensure they held the most up to date information. However, no action had been taken and care plans and risk assessments did not always reflect people's current needs and did not contain all the necessary guidance for staff to support people safely. We have reported more about this in the safe key question of this report. We could not be assured people were receiving safe care and support in line with their assessed needs.
- The audit system in place was ineffective at identifying concerns, when action was needed or evidencing if any action had been taken. Medicine audits were not in place and the provider had failed to identify the concerns we found in the safe management of people's medicines as reported on in the safe key question of this report.
- There was one infection control audit which took place in December 2022, and 2 environment audits completed in December 2022 and January 2023 however, they had not picked up all the concerns we found during our inspection. For example, overflowing rubbish in the garden, fridge and freezer temperatures not being completed or documented and, out of date or unlabelled food in fridges. You can read more about

this in the safe question of this report.
● The manager told us they were the only person completing audits at the service. We spoke to the provider about our concerns in the service and the lack of good governance. The provider told us they completed regular audits at the service. We asked them to provide all audits completed in the last 6 months by them however, these had not been provided at the time of writing this report.
● There was no registered manager at the service at the time of the inspection. The manager had been in post since July 2022 and had applied to become the registered manager on 5 January 2023. The last registered manager left their post in August 2022. The manager told us they had been waiting for their enhanced DBS certificate to arrive.
● The manager told us they didn't have time to complete all the audits due to being so severely short staffed. We asked what support they received from the provider. They told us they had had 3 different managers in the 6 months they had been at the service and had only had 1 supervision in that time. They said, "I have spoken to my manager, HR and the manager before. Nothing has changed. I don't think they know what to do." We observed although there were enough staff which were mostly made up of agency staff, systems and processes had not been effective in ensuring staff were trained and knew what to do.● We spoke with the provider who told us they have provided the manager with weekly calls to HR and offered them the opportunity to work from home 1 day a week. The provider also told us they were proposing to offer transport to new recruits via a taxi firm paid for by the company and were looking at an uplift in hourly rates for staff. They said they would look now, at what additional support could be offered to the manager and the service.

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

● Providers are required to act in an open and transparent way when people come to harm and to notify CQC of significant events without delay. The provider failed to notify CQC of significant events that happened in the service as required by law. This included threats of harm and physical abuse.
● We spoke to the manager about this and asked why incidents of this nature had not been referred to safeguarding or notified to CQC. The manager told us this was because they were deemed as minor incidents. The manager failed to recognise the impact these incidents could have on people and their responsibility to be open and transparent with the Local Authority Safeguarding Team and CQC.

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

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents and incidents occurred.
● A recent notifiable safety incident which put a person a risk of severe harm had been reported to relatives. The provider failed to give an apology to the relevant people and failed to keep a written record of the apology. The provider also failed to put any apology in writing to the person and their relative.
● The manager had no evidence duty of candour had been followed in this instance or any previous instance.

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

● The manager responsive and told us they would notify CQC of any incidents of this nature in future.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People, their relatives and staff were not always engaged and involved.

● There was a lack of systems in place to evidence people were supported to express and review how they wanted their care to be provided. People were not given regular opportunity to discuss their individual care needs or wider issues in the home.

● Staff told us they did not always feel valued or listened to. Staff did not have access to regular supervision. The manager told us they had just implemented a supervision plan.

● Team meeting minutes were provided by the manager following the onsite inspection. Team meeting minutes dated October and December 2022 were both created on 19 January 2023. A third team meeting was shared which was completed and created in September 2022.

● The meeting minutes were brief, for example the meeting in September reminded staff to complete e-learning, count medicines with 2 staff members and to count finances daily and report any medicines errors or finance errors to the manager. There was no opportunity for staff to give feedback. All three meeting minutes stated 'No previous minutes' and stated the meetings were being relaunched but had the name of a different service on them.

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

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

● The culture of the service did not reflect our Right Support, Right Care, Right Culture guidance. People were not adequately supported to have maximum choice, control and independence over their lives. Care was not person-centred and the poor leadership by the provider did not ensure people led empowered lives.

● People did not receive consistent person-centred care that was empowering, of a high-quality and achieved good outcomes. Improvements were needed. These have been reported in the safe and effective questions of this report.

● During our site visit however, we did observe staff treating people in a kind and caring manner. Relatives were complimentary about the care provided by the regular staff.

● Staff told us they enjoyed working at the service although they felt exhausted due to the lack of staff. Staff were complementary about their colleagues and the support they gave them.

● The manager demonstrated commitment to the service and people who lived there however, improvements were needed to ensure they had the knowledge, skills and time to be able to do this.

● We received feedback from 2 professional who had dealt with the manager. Both said they had positive experiences of the manager the manager had mostly been open, honest and responsive.

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The failure to ensure people were provided with person-centred care was a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to establish and operate recruitment procedures effectively was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The failure to act in an open and transparent way was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to ensure staff received appropriate training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Providing care and treatment without the consent of the person or in their best interests following mental capacity legislation was a breach of regulation 11 of the Health and Social Care Act 2008 (regulated Activities) regulations 2014 (Part 3).

The enforcement action we took:

We issued a Warning Notice for the breach of Regulation 11 of the Health and Social Care Act 2008 (regulated Activities) regulations 2014 (Part 3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to ensure people were provided with safe care and treatment and risks were assessed, monitored and mitigated was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Issued a Warning Notice for the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The failure to safeguard people from abuse and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a Warning Notice for the breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The enforcement action we took:

We issued a Warning Notice for the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.